Maternal and Child Health Services
Title V Block Grant

State Narrative for Virginia

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Copies of signed assurances and certifications for Virginia are maintained on file in the Office of Family Health Services, Virginia Department of Health. Copies are available by contacting the Title V Director, Office of Family Health Services, 109 Governor Street, 7th Floor, Richmond, VA 23219 or by phone at (804) 864-7651.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

In Virginia, opportunity for public input into the MCH planning process is ongoing, utilizing the variety of stakeholders and linkages described elsewhere in the application. In FY 2010 Virginia focused specific efforts on obtaining public input for the five-year needs assessment and the FY 2011 Title V application. These efforts included a PowerPoint presentation describing Title V and the MCH services that Virginia provides that was developed and placed on the OFHS website (www.vahealth.org), a survey of district health departments, key stakeholder interviews, and focus groups. Marjory Ruderman from Johns Hopkins University facilitated a priority-setting meeting that included input from external partners as well as the OFHS staff.

During the year routine mechanisms are in place to obtain input and feedback on specific MCH programs. The Office of Family Health Services utilizes advisory groups and task forces that regularly provide input into specific MCH programs. Public notification and the draft MCH Block Grant application and needs assessment were made available on the OFHS website. In addition, emails were sent to numerous stakeholders notifying them of the availability of the draft application. These stakeholders included the following.

35 Health district directors, nurse managers, and business managers
Representatives of the Department of Medical Assistance Services
Care Connection for Children program
Representatives of the Department of Education
The Virginia Chapter of the AAP
Genetics Advisory Committee
Early Hearing Detection Initiative Advisory Board
Family Voices
Parent to Parent
Medical Home Plus
Virginia Family-to-Family Center
Virginia Bleeding Disorders Program

Va-Lend (VA leadership Education in Neurodevelopmental Disabilities Program at VCU)
Parents of CSHCN
Infant and Toddler Connection staff

After transmittal to MCHB, the final application and needs assessment will be available on the OFHS website. The OFHS will continue to seek opportunities during FY 2011 to present information on Virginia's title V funded programs at various meetings with interested parties and obtain input.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The agency vision of achieving healthy people in healthy communities is actualized through the strengthening of partnerships between the state Title V agency and stakeholders that include federal, state, and local MCH partners. The needs assessment contributes to the achievement of these goals by identifying needs for preventive and primary care services for pregnant women, parents, and infants, preventative and primary care services for children, and services for Children with Special Health Care Needs (CSHCN) and examining the capacity of the state to provide services by each level of the MCH pyramid.

A needs assessment team made up of representatives from the Office of Family Health Services (OFHS) was formed to lead the assessment efforts. The OFHS Needs Assessment Team was made up of representatives from each of the six OFHS divisions (Division of Women and Infant Health, Division of Child and Adolescent Health, Division of Dental Health, Division of Injury and Violence Prevention, Division of Chronic Disease Prevention and Control, and Division of Nutrition, Physical Activity, and Food Programs) and led by the Policy and Assessment Unit staff.

The data analysis phase provided an evidence base to identify priority needs for MCH populations and assess capacity to address those needs. Both quantitative and qualitative methods were used to assess the strengths and needs of each of the MCH populations. To the extent possible with each data source, indicators were examined by race/ethnicity, age, education, insurance status, income, and geography. Results of trend analyses on the Title V National and State Performance Measures were used to describe progress on risk factors and outcomes.

A combination of quantitative data sources and qualitative information was used to assess the state's capacity to provide direct health care, enabling, population-based, and infrastructure building services. The Title V Health Systems Capacity Indicators, and National and State Performance Measures were used to assess trends over time in the utilization and provision of preventive services, prenatal care utilization, asthma hospitalizations, high-risk deliveries at appropriate facilities, hearing screening follow-up, and dental providers in underserved areas. The Nurse Managers of the state's 35 Health Districts were surveyed to identify services provided, needs of their population, the district's capacity to meet those needs, and the partnerships utilized in their district. Key informant interviews and focus groups were used to identify challenges in meeting the needs of Virginia's MCH populations.

Current capacity in OFHS was compared to capacity at the time of the 2005 needs assessment to determine the impact of changes in national and state policies, program staffing, activities of state and local partners, and loss of funding. As the team reviewed the data on needs of each population group, capacity to meet identified needs was discussed in the context of the current economic, political, and budgetary climates.

Stakeholders had an integral role in the needs assessment, particularly in assessment of the needs of the three Title V priority populations and whether providers and consumers perceived that VDH had the capacity to address the needs of MCH populations. Stakeholder input was invited through three main avenues 1) Focus Groups, 2) Key Informant Interviews, and 3) Stakeholder Input Meeting.

The stakeholder input meeting was held on May 17, 2010, and was facilitated by Marjory Ruderman, a consultant who had conducted a CAST-5 assessment for OFHS in 2004/05. Data highlights from the Title V Needs Assessment were provided as an evidence base for the stakeholder discussion. Following the data presentation, groups were formed according to the three Title V priority populations. Each group was asked to brainstorm a list of needs, using questions as prompts. As a result, 18 top needs were identified by participants.

On May 19, 2010 the six OFHS Division Directors, along with the three primary planning and data staff and the acting OFHS director, met to finalize a list of up to 10 priorities with measurable indicators.

A discussion of the priorities adopted in 2005 highlighted a number of issues that participants wished to avoid with the priorities adopted for 2011-2015:

- 2005 priorities lacked usefulness in planning and evaluating efforts.
- Disconnect between priorities and resource allocation.
- Priorities did not balance "what we'd like to do" with "what we have to do."
- Broad priorities were not aligned with the OFHS' pragmatic approach to addressing health status.

As a result of the discussion of the broad priorities identified in the 2005 needs assessment, the 18 priorities identified by the stakeholders, and areas to be considered when narrowing down the priorities, the Division Directors reached a consensus on eight MCH priorities for FFY 2011-2015. They also agreed that the list of 18 priorities identified by the stakeholders at the initial priority setting meeting would provide guidance for ongoing OFHS planning and mplementation. The final priorities were linked to the National Performance Measures and ten new state performance measures that will be used to track progress in addressing the priorities. The priorities address the three major MCH population groups (pregnant women, mothers and infants; children, and CSHCN). The following are the Title V priorities for 2011-2015.

1. Reduce infant mortality
2. Reduce injury, violence and suicide among Title V populations
3. Increase access to dental care and population-based prevention of dental disease across the lifespan
4. Decrease childhood obesity
5. Decrease childhood hunger
6. Improve access to health care services for children and youth with special health care needs by promoting medical home
7. Promote independence of young adults with special health care needs by strengthening transition supports and services
8. Support optimal

III. State Overview

A. Overview

Geographic Description

The Commonwealth of Virginia is a mid-Atlantic state, bordered by Washington D.C., the nation's capitol, and Maryland to the north; the Atlantic Ocean to the east; North Carolina and to the south; and Tennessee, West Virginia and Kentucky to the west. Virginia encompasses 42,774 square miles (110,784 km2) making it the thirty-fifth largest state by area. The Virginia Department of Health has grouped its 134 localities (cities and counties) into 35 health districts and 5 health planning regions. The Northern Region, composed of Loudoun, Fairfax, Alexandria, Arlington and Prince William health districts located just south of Washington, D.C., is densely populated and includes six of the twenty highest income counties in the United States. However, with over 150 languages spoken in the region, and limited translation and interpretation services, communication can be problematic and interfere with access to health services. In addition, this region has severe daily traffic congestion. Conversely, the Southwest Region, made up of Lenowisco, Cumberland Plateau, Mount Rogers, West Piedmont, New River, Alleghany and Roanoke health districts, bordered by West Virginia, Kentucky and Tennessee, is rural with a rugged and mountainous terrain and it is the least populous and least racial/ethnically diverse. Its terrain and vast geographic area pose many transportation barriers. Ice and snow during the winter months can hamper travel. The East Central Region is composed of Southside, Piedmont, Crater, Chesterfield, Richmond, Henrico, Chickahominy, Three Rivers and Rappahannock health districts. West Central Region is made up of Pittsylvania/Danville, Central Virginia, Thomas Jefferson, Central Shenandoah, Rappahannock/Rapidan and Lord Fairfax. These two regions have a mix of urban, suburban and rural areas. The urban areas are home to large state universities/ colleges and are business districts. The suburban areas are more residential than industrial. The rural areas are agricultural. The Eastern Region, composed of Western Tidewater, Chesapeake, Virginia Beach, Portsmouth, Norfolk, Hampton, Peninsula, and Eastern Shore health districts, runs along the east coast (Chesapeake Bay and Atlantic Ocean) and includes the Eastern Shore, a peninsula separated from the mainland by the Chesapeake Bay. The Eastern Shore Health District is very sparsely populated and has high poverty. The Eastern region has the largest concentration of military bases and facilities of any metropolitan area in the world. The coastal region has many bridges and tunnels that create transportation barriers to services. The region also has daily severe traffic congestion. Occasionally, hurricanes and tropical storms affect the area and can bring flooding. More information regarding local health districts can be found at www.vdh.virginia.gov/lhd.

Demographic Description

Virginia's population is growing and changing. It reached 7.77 million in 2008, maintaining the Commonwealth's position as the 12th largest state population in the country with an annual growth rate of about 1.12 percent since 2000. In 2007, among people reporting one race alone, 70 percent were non-Hispanic White, 20 percent were non-Hispanic Black, and 5 percent were Asian. Compared to the nation, Virginia had a slightly higher proportion of Black or African American population. The proportion of Hispanics in Virginia (6.5%) was significantly lower than the national average (15.1%). The majority of the minority populations in Virginia reside in the three major metropolitan areas of the state. Within Virginia, two metropolitan areas are clearly much more densely populated and developed than other areas of the state: The Northern region has the largest number of housing units and people per square mile, followed closely by Hampton Roads. In 2008, the Northern region had a housing density of 324.3 per square mile, while Hampton Roads was at 285.0 homes. The Southside region had the sparsest housing density at only 28.8 houses per square mile. Housing density is closely correlated with population density data. In this, too, the Northern and Hampton Roads regions have the highest population density rates, while the Southside region has the lowest in the state. In 2000, 73 percent of Virginia's population lived in urban areas, lower than the national average of 79 percent. California had the highest percent (94%) of people living in urban areas. The urban population rates for North

Carolina, Tennessee and Maryland were 60 percent, 64 percent and 86 percent respectively. Not surprisingly, urban populations within Virginia are largest in Hampton Roads, with 92 percent, and the Northern Region, with 91 percent. The Southwest and Southside regions had the largest rural populations, at 75 percent and 65 percent respectively.

Virginia's population has grown by more than 800,000 since the 2000 census -- a growth rate of 11.4 percent over nine years. The Commonwealth's 1.12 percent annual growth rate between 2000 and 2008 was 15th highest among states, and higher than the nation's rate of 94 percent. The 2009 provisional state population estimate is 7,882,590, which represents an increase of more than 87,000 since 2008. Virginia's metropolitan areas account for 93.5 percent of the population growth since 2000; as a result, by July 2009, more than 85.7 percent of Virginians lived in one of the state's metropolitan areas. Rural and small-town Virginia represents a diminishing share of the state's population. While some urban localities (such as Fairfax, Chesterfield and Chesapeake) have large increases in population, they may not register as among those with the fastest rate of growth, due to the size of their population.
According to the University of Virginia's Weldon Cooper Center for Public Service, three critical trends will shape Virginia's population over the next few decades: selective decentralization, an aging population, and increasing racial and ethnic diversity. As noted earlier, people are moving away from the state's central cities and counties to the surrounding suburbs and exurbs, thus increasing selective decentralization. As a result, the number of metropolitan areas is expected to increase, and the boundaries of existing metro areas are expected to expand. Rural counties adjacent to metro areas are likely to experience significant population growth as space and affordable housing become harder to obtain in the urban core areas. Counties with significant quality-of-life advantages, those with access to urban amenities (either their own or nearby), and those with a diversified, service-based economy are particularly prone to rapid growth. The state's 11 metropolitan areas contained about 86 percent of the total population in 2007 and almost 69 percent of all Virginians lived in just three metropolitan areas: Northern Virginia, Richmond, and Virginia Beach. These three metropolitan areas accounted for more than 83 percent of state population growth from 2000 to 2007.

The population will continue to age. About 21.9 percent of all households in 2007 had one or more persons age 65 years and older and 39.4 percent of persons age 65 years and older had a disability. In Virginia today, older adults comprise 11 percent of people receiving Medicaid services yet drive nearly 25 percent of Virginia's total Medicaid spending and 50 percent of Medicaid spending on long-term care services. As the population grows and ages in the next 20 years, many more people will become dependent on Medicare and Medicaid for health insurance coverage.

The average age of the population will increase as the baby boom generation enters retirement age. The population of Virginians age 60 and over will grow from 14.7 percent of the total population in 1990 to almost 25 percent by 2025 when there will be more than 2 million Virginians in this age group. By 2030, nearly one in every five Virginians is projected to be 65 years or older. As the Baby Boomer generation ages, the gap between male and female life expectancy is expected to narrow as a result of health advances. Women of that generation are also better educated than in the past and will be less likely to live in poverty. Some 70 percent of Virginia's seniors today live in metro areas, especially Northern Virginia, Hampton Roads and Richmond. But the localities with the highest proportion of seniors tend to be rural localities, as young people have left or retirees have moved in. Aging boomers have fewer children to care for them as they become elderly parents and grandparents. Delayed fertility and increased longevity increases the likelihood of ‘sandwich responsibilities for children of boomers- caring for their on children and their parents as well.

The number of Virginians age 85 and older will increase dramatically between 1990 and 2025 -- five times faster than the state's total population growth. This population will be predominantly female, as women have a longer life expectancy than men. As the baby boomers age, the percentage of older workers will increase as will the average age of the labor force. The senior

population will have vastly different levels of needs, abilities and resources. The oldest seniors are more likely to live in poverty, to be less-educated and to have more health problems. Elderly women significantly outnumber elderly men. Among those 85 and older, the ratio is more than two to one. Women are more likely to be widowed and to live alone and in poverty. While the senior population in Virginia is less diverse than the population overall, in the coming decades, the percent of older Virginians who are minorities will continue to grow.

In Virginia, 40 percent of grandparents are living with their own grandchildren and 6.2 percent of all children or 107,602 are being raised in a home where the grandparent is the head of household, often without a parent present at all. According to AARP, 59,464 grandparents report they are raising their grandchildren in Virginia. Of these, 40 percent are African American; 3 percent are Hispanic/Latino; 3 percent are Asian; and 52 percent are White. Grandparents raising grandchildren must establish legal custody in order to enroll grandchildren in school, access medical records and apply for benefits. The process of gaining legal custody or guardianship can be expensive, emotionally draining and confusing. These grandparents are 60 percent more likely to live in poverty than grandparents who are not responsible for children. The cost of caring for children can be overwhelming for those on a fixed income. Many grandparents make significant employment changes such as delaying retirement or quitting work sooner than planned in order to care for children.

The minority population (all who indicate they are Hispanic or a race other than white only) has grown since 1980.Approximately 48 percent of Virginia's population was born in another state or nation. New residents from other states tend to be younger, better educated and earn more than native Virginians. In 2007, there were more than 794,000 foreign-born Virginians, an increase from about 570,000 in 2000.Immigrants tended to be younger and divided between the less- and better-educated population segments. The mix of immigrants in Virginia included a higher percentage of Asians compared to the national average. Virginia's most racially and ethnically diverse communities are in Northern Virginia and the Tidewater area. In Tidewater, where the population is mostly comprised of non-Hispanic White and non- Hispanic Black, it is also home to one of the largest Asian populations in the state. While non-Hispanic Whites will continue to be the majority of Virginia's population in the next few decades, the proportion of Asians and Hispanics will grow.

Virginia's Hispanic population tripled between 1990 and 2006. Hispanics account for 6 percent of Virginia's population, compared to 15 percent nationwide. Participation in the labor force (defined as currently working or actively looking for work) characterizes 68 percent of Vir¬ginians age 16 and above, and 80 percent of Hispanic im¬migrants. Hispanic immigrants account for 3.4 percent of Virginia's la¬bor force. Employed in a wide range of occupations, they are concentrated in a few occupational sectors that require little education. For example, Hispanic immigrants represent nearly 15 percent of workers in construction, farming, and buildings & grounds cleaning and maintenance. Food prepa¬ration and serving also employ large numbers of Hispanic immigrants. Additionally, more than 3 percent of Virginia's military employees are Hispanic immigrants.

The distribution of Virginia's Hispanic population is highly un¬even, concentrating in the state's three major metropolitan areas, and selected rural areas. In Northern Virginia, Hispanics represent more than 15 percent of the populations of Manassas Park City, Manassas City, Prince William County, and Arlington County; Fairfax County, the largest county in Virginia, is home to more than one-quarter of all of Virginia's Hispanic residents. Additionally, a number of rural localities in Virginia show a significant increase in the number of Hispanics residents. Included among them is Galax City in Southwest Virginia, with 14 percent of its population being Hispanic. Forty percent of Hispanics in Virginia are immigrants, both authorized and unauthorized.

Hispanic immigrants are less educated, poorer, more likely to lack health insurance, and live in larger households than the overall population. Hispanics (both citizens and immigrants) received benefits and were over-represented in two social welfare programs (WIC and job training) and two public subsidy programs (rent subsidies and free-and-reduced-price school lunch). Of 17,000

job-training recipients, 7 percent were Hispanics. Hispanic households are also over-represented in uptake of rent subsidies and free and reduced priced lunch (accounting for 20 and 16 percent, respectively, of the total recipient households), but were significantly under-represented in the remaining three categories (public housing, food stamps, and energy subsidies). Hispanic immigrants and their children receive little welfare other than WIC and school lunch subsidies. Hispanic immigrants are less likely to have health insurance than the overall population. In 2006, 57 percent of Hispanic immigrants lacked health insurance, compared to 27 percent of Hispanic citizens, and 14 percent of all Virginians.

Economy

According to The Council for Virginia's Future, poverty has a significant impact on individuals and society at large. Children who live in poverty are likely to suffer from poor nutrition during infancy, experience emotional distress, and have an increased risk for academic failure and teenage pregnancy. Adult men and women who live in poverty are at high risk of poor health and violence. Poverty can also affect seniors' ability to care for themselves or to obtain prescription medication. Virginia had the 12th lowest poverty rate in the nation in 2008. 10.2 percent of Virginians fell below the federal poverty level, which in 2008 was $10,991 for an individual. The national average was 13.2 percent in 2008. There was an increase in the percent in poverty, from 8.74 in 2002. In 2007, poverty most affected Black (18.2 percent) and Hispanic (13.3 percent) residents compared to White residents (7.7 percent).

In 2008 the Southside region had the highest percentage (18.5%) of individuals living below the poverty level of any region in the state, followed by the Southwest (18.1%) and Eastern (15.0%) regions. At the other end of the scale, the Northern region (5.4%) had the lowest percentage of individuals living below the poverty level, followed by the Central (10.7%) and Hampton Roads (11.0%) regions. Among Virginia's peers, Maryland had the lowest poverty rate at 8.1 percent, while North Carolina and Tennessee both had higher rates of poverty at 14.6 and 15.5 percent respectively.

The percentage of children in poverty has increased from 12 percent in 2000 to 13 percent in 2007. The US rate of children living in poverty for 2007 and 2008 is 18%. More recently, in 2008, 14 percent of Virginia children were living in poverty, 6 percent were living in extreme poverty; 22 percent were below 150% poverty. Thirty percent of children living in poverty were Black/African American, 8 percent were non-Hispanic white, and 16 percent were Hispanic or Latino.

According to the Council for Virginia's Future, per capita personal income includes wages and salaries, transfer payments, dividends, interest, and rental income and is used as the broadest indicator of the magnitude of improvement in an economy. Rising income levels allow individuals to provide for their families, buy homes and improve the quality of their lives.

In 2008, Virginia ranked seventh among the states in per capita personal income, with $44,224 per capita income (in 2008 dollars). Relative to its peers, Virginia's per capita income was lower than Maryland, ($48,378) in 2008, but higher than North Carolina ($35,344) and Tennessee ($34,976). National per capita income stood at $40,194. Within Virginia, the Northern region had the highest per capita personal income in 2007 at $56,981 (in 2007 dollars), while the Central region had the second-highest ($39,719). At the other end of the spectrum, the Southside and Southwest regions had the lowest per capita personal income at $25,527 and $26,264, respectively.

Between 2000 and 2008 Virginia's per capita income grew at a rate of 1.4 percent, compared to the national average of 0.7 percent over the same period. Within Virginia, Hampton Roads had the fastest growth rate at 2.2 percent between 2000 and 2007.

Median household income has increased from $36,367 in 1995 to $61, 210 in 2008. The US median household income has increased from $50,800 in 2004 to $58,900. The median family (with child) income was $69,400 in 2008, up from $57,200 in 2004. The number of households

receiving Food Stamps has increased from 160,345 in 2002 to 253,273 in 2008. The TANF rates increased from 46 TANF recipients per 1,000 children in 1998 to 111 per 1,000 children in 2008.

Employment

According to Virginian Performs, employment growth is an indicator of expansion in the economy and represents an increase in the economic opportunities available to the citizens of a region or state. Employment growth is generally tracked as a percentage change from a previous year. Between 2000 and 2005, Virginia's employment grew at a faster rate than the national average but it lagged U.S. growth during 2006-2008. Virginia's 2007-08 employment growth rate of 1.04 percent exceeded Tennessee (0.71 percent) but was slightly slower than Maryland (1.12 percent) and North Carolina (1.06 percent). Regional employment growth data in 2007 indicate that the Northern region (2.71 percent) had the fastest growing rate in the state over the previous year. The Central region exhibited the second highest employment growth at 2.64 percent, while the West Central region registered 1.76 percent employment growth. Virginia's remaining regions all saw rates at or below 1.64 percent. In 2006-2008, for the employed population 16 years and older, the leading industries in Virginia were educational services, and health care, and social assistance (20 %), and professional, scientific, and management, and administrative and waste management services, (14 %). Among the most common occupations were: management, professional, and related occupations (40 %), sales and office occupations (24 %), service occupations (15 %) production, transportation, and material moving occupations (10 %) and construction, extraction, maintenance and repair occupations (10 %). Seventy-four percent of the people employed were private wage and salary workers; and 20 percent were Federal, state, or local government workers.

Unemployment is a measure of how many people without jobs are actively seeking employment. According to Virginia Performs, since most people earn a living through a job, unemployment is also a measure of how the economy is doing in providing opportunities for Virginians to support themselves and their families. Unemployment not only hurts the personal finances of those without jobs, but also reduces their participation in the overall economy. The inability to find work is also associated with psychological stress, health problems, and stress on family relationships. Only people who have jobs or who are actively seeking one are part of the labor force; unemployed people who have stopped looking for a job are no longer counted as members of the labor force.

In 2008, Virginia, with a 4.0 percent unemployment rate, ranked ninth among the states. South Dakota had the lowest unemployment rate at 3.0 percent. Virginia's 2008 rate was lower than its peers, North Carolina (6.3%), Tennessee (6.4%) and Maryland (4.4%), and lower than the national rate of 5.8 percent. Across the state, the unemployment rate varied in 2008 from a high of 7.2 percent in the Southside region to a low of 3.0 percent in the Northern Region. The central tier of the state (Central and West Central regions) had rates between 4.2 percent and 4.3 percent. The Southwest region was second highest with 5.4 percent unemployment. In the last decade, the Southside and Southwest regions have routinely experienced higher rates of unemployment than other regions, largely due to the loss of manufacturing jobs and limited economic growth. More recently, the Virginia unemployment rate for December 2009 was 6.7 percent, an increase of 1.6 percent from December 2008 (5.1%). Virginia's rate is lower than the US rate of 9.7 percent.

Examination of Virginia's unemployment by industry reveals that certain fields, such as construction, administrative and waste services, accommodation and food services, manufacturing, and health care and social assistance, have relatively higher rates of unemployment. Financial services, government, transportation, and education and health care have relatively lower unemployment rates than other industries in the state. There were 330 mass layoff events in the state in 2009; representing a 184.5% increase from 2008. Total unemployment insurance claimants increased from 42,809 in 2005 to 104,212 in 2009. In 2007, 27 percent of children were living in families where no parent has a full-time, year-round employment and 3 percent were living in low-income households where no adults work. In 2008,

63 percent of teens ages16 to 19 were unemployed.

Health

Virginia is 21st in health this year, unchanged from 2008. Strengths include a low prevalence of smoking at 16.4 percent of the population, a low violent crime rate at 256 offenses per 100.000 population, ready availability of primary care physicians with 125.0 primary care physicians per 100,000 population and few poor mental health days per month at 3.0 days in the previous 30 days. Virginia ranks higher for health determinants than for health outcomes, indicating that overall healthiness should improve over time. Challenges include high levels of air pollution at 12.1 micrograms of fine particulate per cubic meter, low immunization coverage with 73.2 percent of children ages 19 to 35 months receiving complete immunizations and high geographic disparity within the state at 14.9 percent. In the past year, the rate of preventable hospitalizations decreased from 70.2 to 64.8 discharges per 1,000 Medicare enrollees. In the past five years, the prevalence of smoking decreased from 22.0 percent to 16.4 percent of the population. In the past ten years, the rate of deaths from cardiovascular disease decreased from 361.4 to 282.1 deaths per 100,000 population. Since 1990, the prevalence of obesity increased from 9.9 percent to 25.5 percent of the population. In Virginia, obesity is more prevalent among non-Hispanic blacks at 34.3 percent than non-Hispanic whites at 24.0 percent. The WIC data on children shows the significant increasing trend in overweight and obesity. In 2001, 17.4% WIC children were overweight or obese as compared to 33.5% in 2009. This is just one specific population, but the data highlights the increasing overweight and obesity for all children. The prevalence of diabetes also varies by race and ethnicity in the state; 14.9 percent of non-Hispanic blacks have diabetes compared to 7.0 percent of non-Hispanic whites. In addition, mortality rates vary in Virginia, with 1,012.4 deaths per 100,000 population among blacks compared to whites, who experience 791.6 deaths per 100,000 population.

Some other health status indicators that highlight the challenges that Virginia faces include unintentional injuries, birth outcomes, and births to teens. Injuries took the lives of 3,929 Virginians in 2008, making this the third leading cause of death. Motor vehicle crashes accounted for approximately 1 out of every 5 of these fatalities. Although there is a continuing decline in child deaths, the leading cause of death for Virginia children is injury. Violent and abusive behavior has been increasingly recognized as an important public health issue. In 2008, 374 people were homicide victims in Virginia. Of the 374 homicides, the majority died by firearm. Approximately 18 percent of all the deaths in the 15 to 19 year-olds were classified as homicides in 2008. Homicide disproportionately affects young African American males. Fifty-nine youth ages 10-19 died from self-inflicted injuries in 2008.

The racial disparity in a number of health status indicators also presents significant challenges. For example, the infant death rate is often used as a state health status indicator. In 2008, the rate was 6.7 per 1,000 live births, down from 7.7 in 2007. However, there continues to be a large disparity between the rates for white non-Hispanic and for black non-Hispanic infants. In 2008, the infant death rate for white non-Hispanic infants was 5.1/1,000 as compared to 12.1/1,000 for black non-Hispanic infants. Low birth weight is an indicator of limited access to health care and a major predictor of infant mortality. In 2008, 8.3 percent of births were low birth weight infants. This represents a significant increasing trend since 1999. The rate of births to teens aged 15 through 17 years old has decreased from 24.9/1,000 in 1999 to 15.4/1,000 in 2008.

Health Insurance

Families USA estimates that more than 10 working-age Virginians die each week due to lack of health insurance (approximately 550 people in 2006). Between 2000 and 2006, the estimated number of adults between the ages of 25and 64 in Virginia who died because they did not have health insurance was more than 3,200. According to Virginia Performs, estimates of uninsurance in Virginia over the past several years have ranged from 10 percent to 15 percent of the total population; the range is due to differences in survey methodology, changes in policies and demographics, and fluctuations in the economy. Based on U.S. Census Bureau estimates, the national average for uninsured people was 15.4 percent in 2008. In the same year, Virginia's rate

was 12.4 percent, ranking it 22nd among all states. According to the 2007 National Survey of Children's Health, about 93 percent of Virginia's children ages 0-17 were currently insured, higher than the US rate of 91 percent. About 12 percent of those surveyed reported lacking consistent insurance coverage in past year, lower than the US rate of 15 percent.

In comparison with its peers, Virginia had a lower percentage of uninsured individuals than North Carolina (15.4%) and Tennessee (15.1%) but a higher one than Maryland (12.1%). The Eastern (20.2 percent), Valley (16.9), Southwest (16.1), West Central and Northern (16.0), and Southside (15.7) regions exceeded this statewide average. The Hampton Roads region had the lowest rate at 13.7. The private sector, which insures about 68 percent of the population, provides insurance for families of workers and their dependents but does not cover the cost of long-term care. The public sector -- through Medicare at the federal level and Medicaid at the state level -- provides insurance for about 22 percent of the population, with services targeted to vulnerable persons including the poor, elderly and disabled. From FY 2007 to FY 2008, enrollment in Virginia's FAMIS/SCHIP program increased from 80,024 children to 85,977 children. Medicaid enrollment increased from 649,903 to 665,800 during the same period. The rate of Virginians dependent on Medicaid has increased from 7 to nearly 9 percent over the past five years. About 8 percent of the population covers medical insurance out of their own pockets. The remaining 12 percent of the population is uninsured. According to Virginia Health Care Foundations' Profile of the Uninsured, the vast majority of the uninsured (80%) live in households with at least one full-time (65%) or part-time (15%) worker. Forty-six percent of uninsured Virginians live in households with a worker employed by a small company (100 or fewer employees) or with a self-employed worker. In contrast, less than 8 percent of those in companies with 500 employees or more are uninsured. Only one in four uninsured Virginians (26.8%) lives in households that have an offer of employer-sponsored health insurance. The overwhelming majority of Virginians without insurance are U.S. citizens (81%). Fifty percent of uninsured Virginia adults are Caucasian/non-Hispanic, 20 percent are African-American, 20 percent are Hispanic, and 10 percent classify themselves as "other."

Housing

According to the 2000 Census, Virginia's home ownership rate was 68 percent, slightly higher than the US (66 %). The downturn in Virginia's economy has impacted home foreclosures. In April 2010, 1 in 467 Virginia housing units received a foreclosure filing notice. Fairfax and Prince William had the highest number of units receiving a notice in April. The population per household was 2.54 and 3.2 percent lived in crowded housing. Less than 1 percent of occupied units lacked complete plumbing or complete kitchen. A housing unit is considered crowded if there is more than 1 person per room. In 2008, 7 percent of Virginia's children lived in crowded housing; 13 percent of these children were in immigrant families. For the same year, the national rate of children living in crowded housing was 13 percent. In 2008, 66 percent of Virginia's children lived in low-income households where housing costs exceeded 30 percent of income; the same rate as in the US. Forty-nine percent were children in immigrant families, roughly the same percent (51%) as for the US. According to the 2007 National Survey of Children's Health, with respect to neighborhood amenities, 44.9 percent of Virginia children live in neighborhoods with a park, sidewalks, a library, and a community center compared to 48.2 percent of US children. Eleven percent of Virginia children live in neighborhoods with poorly kept or dilapidated housing, lower than the US rate of 14.6 percent. Eighty-three percent of children live in supportive neighborhoods, about the same as the national rate (85%). Almost ninety percent live in neighborhoods that are usually or always safe, higher than the US rate (86.1 %).

Education

According to Virginia Performs, the high school graduation rate is one measure of the success of a state's elementary and secondary educational system and the quality of its workforce. Completion of high school or its equivalent is increasingly the minimum level of education sought by employers; moreover, unemployment rates are lower and lifetime earnings are substantially higher for high school graduates than for high school dropouts. Graduation rates improved for each of Virginia's regions in 2008-2009 compared to 2007-2008 with the statewide average increasing from 82.2 percent to 83.2 percent. The Northern region (87.8%) has a rate that

exceeds the statewide average, while the Southwest (83%), Valley (82.9%), Southside and Central (82.3%), West Central (81.3%), Hampton Roads (80.6%), and Eastern region (78.1%) have graduation rates that are below the statewide average.

The student dropout rate has declined over time from 2.2 percent in 2002 to 1.9 percent in 2007. In 2008, 4 percent of teens were high school dropouts, down from 7 percent in 2004. In 2009, the dropout rate for Hispanic/Latino youth was 10 percent, for black non-Hispanic the rate was 3 percent and for white non-Hispanic the rate was 3 percent. The US rate for dropouts was 6 percent in 2008.

Virginia's educational attainment is slightly above the national average in terms of individuals with a high school education, but well above average for individuals with higher education. In 2008, Virginia ranked 30th in the nation for the highest percentage of its adult population (25 years or older) with at least a high school degree, but 6th for adults with at least a bachelor's degree.

In Virginia, 85.9 percent of adults had at least a high school degree in 2008, exceeding the national average of 85.0 percent. Neighboring states Tennessee (83.0%), North Carolina (83.6%), and Maryland (88.0%) also performed well, but Wyoming led the nation at 91.7 percent high school graduation. The percentage of Virginia's adult population with at least a bachelor's degree increased from 31.7 percent in 2002 to 33.7 percent in 2008, exceeding the national rate of 27.7 percent. Comparing rates of individuals with at least a bachelor's degree, Virginia is behind Maryland's rate of 35.2 percent, but above North Carolina (26.1%) and Tennessee (22.9%). Massachusetts led the states in 2008 with a rate of 38.1 percent of residents with a bachelor's degree or above. Educational attainment increased in every region across Virginia between 1990 and 2000. All regions increased both their high school- and college-educated population, with the Northern and Hampton Roads regions having the highest high school-educated population, and the Northern and Central regions having the highest college-educated populations.

Agency Accountability and Strategic Planning
House Bill 2097, passed by the 2003 General Assembly, requires that each state agency implement a state performance-based budgeting system. Since that time, an ad hoc advisory group of agency representatives designed the new planning and budgeting model that requires all state agencies to have strategic plans that are tied to their budget and use common language and format. The planning process was unveiled to agency heads by Governor Warner in December 2004. Since that time state agencies, including VDH, have developed their strategic plans and are service plans (operational plans) that are tied to the strategic plan and budgets. This significant change in state government planning and budgeting creates a greater transparency in government by making public how tax payer dollars are spent and the return on investment.

As a result, the VDH strategic plan identified 41 service areas and developed a service area plan for each. The following four service areas are relate to state Title V activities:
Women's and Infants' Health
Injury and Violence Prevention
Child and Adolescent Health
Chronic Disease Prevention, Health Promotion and Oral Health

VDH monitors a series of agency performance measures that are tied to the service areas and are publicly reported on the Virginia Performs website http://vaperforms.virginia.gov/

The VDH Strategic Plan, including MCH related components, is available on the web at http://www.vdh.virginia.gov/Administration/StrategicPlan/.

State MCH Priorities

The Virginia Title V program staff collaborate with a number of agencies within the Virginia Secretariat of Health and Human Resources (SHHR) to identify and jointly address the needs of the MCH populations. Regular meetings with other agencies, cross-agency program development, workgroups and special taskforces assist in the identification of issues and the prioritization of Title V efforts. These agencies within the SHHR include the Department of Behavioral Health and Developmental Services (DBHDS), formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Social Services, the Department of Medical Assistance Services, the Department of Health Professions, and others. In addition, collaborative meetings with agencies outside the SHHR include the Department of Education, the Joint Commission on Health Care, the Youth Commission and various legislative committees. Title V program staff also collaborate with and seek input from professional organizations, consumer representatives, advocacy groups and community providers as well as internally with offices within the VDH such as the Office of Minority Health and Public Health Policy, and the Division of STD/AIDS within the Office of Epidemiology.

For the FY 2011 needs assessment OFHS initiated special efforts to involve our external partners in setting the MCH priorities. The needs assessment process included the collection of qualitative data through focus groups, key stakeholder interviews and a survey of district health department nurse managers. In addition, Marjory Ruderman, a consultant affiliated with Johns Hopkins University, facilitated priority setting meetings of OFHS staff and external stakeholders. During the meetings the MCH priorities were developed based on the presentation of needs assessment data and the needs identified by participants along with some overarching principles to guide our approach to addressing the needs of Virginia's families over the next five years. These overarching principles include continuing to recognize and address health disparities and the social determinates of health, continuing to use a socio-ecological approach to health that addresses social and environmental determinants and promotes safe and healthy communities, increasing family involvement, increasing workforce capacity for medical, dental, mental health and non traditional providers, making resources available for both providers and families, and continuing to focus program planning and strategy development on the life course perspective. These overarching principles will inform our work in addressing the 2011 MCH priorities.

The 2011 Title V needs assessment process served as an essential tool to reflect on system changes and examine the health status of Virginia's families. Although there have been improvements in some areas, there continues to be disparities based on race, income, age, insurance coverage and areas of the state. These variations continue to present challenges. During the next year, the Title V efforts will focus on 1) reducing infant mortality; 2) reducing injuries, violence, and suicide among Title V populations; 3) Increase access to dental care and population-based prevention of dental disease across the lifespan; 4) decreasing childhood obesity; 5) decreasing childhood hunger; 6) improving access to health care services for CYSHCN; 7) promoting independence of young adults with special health care needs; and, 8) supporting optimal child development.

More detailed MCH-related health status indicators are reported in the FY 2006 Needs Assessment. Virginia's MCH priorities are listed in Section IV of this application. In addition, other emerging health trends, problems, gaps and barriers are also identified in the Needs Assessment Section.

B. Agency Capacity

The Office of Family Health Services (OFHS) within the Virginia Department of Health has responsibility for the development and implementation of the MCH Block Grant. The mission of Virginia's MCH efforts is to protect, promote and improve the health and well-being of women,

children, adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities and strengthening the MCH infrastructure. The Office of Family Health Services is comprised of the divisions of Women's and Infants' Health, Child and Adolescent Health, Dental Health, Physical Activity, Nutrition and Food Programs, Chronic Disease Prevention and Control and Injury and Violence Prevention. The director of the OFHS is Diane Helentjaris, MD. She was appointed effective May 25, 2010 following the retirement of David Suttle, MD.

MCH programs and services in Virginia are provided at each of the four levels of the MCH pyramid to protect and promote the health of women and children, including those with special health care needs. The programs and services are funded by Title V, Title X, a number of federal categorical grants and state funds.

The Division of Women's and Infants' Health (DWIH) assesses and advocates for the health needs of infants and of women, particularly women of childbearing age. Joan Corder-Mabe, R.N.C., M.S., W.H.N.P., serves as the division director. Title V, state funds and federal categorical grant funds, including Title X Family Planning funds, support the division work. The breast and cervical cancer screening program, Every Woman's Life (EWL), provides breast and cervical cancer screening, referral and follow-up to low income Virginia women. In 2008, Virginia was awarded a CDC grant to establish a WISEWOMAN program as a part of the EWL program. The program provides lifestyle counselors that provide health screenings, counseling, materials, education and referrals to community resources. The screenings include blood pressure, glucose, cholesterol measurement as well as assessing weight, medical history, tobacco use, adequate diet and physical activity. The WISEWOMAN program works closely with the Division of Chronic Disease and Control's Heart Disease and Stroke Prevention program, Diabetes Prevention and Control program and the Tobacco Use Control project. The division also provides comprehensive family planning services in local health departments (supported by Title X grant funds) to assist low-income women to plan and space their pregnancies. In the past, the Voluntary Sterilization program, managed by the DWIH, has utilized state funds to provide permanent birth control methods to low income individuals, male and female, age 21 and over, who wish to conclude their ability to reproduce children. A number of local health departments use Title V funds to provide prenatal care. Several programs aim at reducing infant mortality and morbidity through home visiting, regional coalition activities (Regional Perinatal Councils), mentoring pregnant teens (Resource Mothers), nutrition counseling, nurse case management, fetal and infant mortality reviews (FIMR), community-based projects and public and professional education. The Virginia Healthy Start program "Loving Steps", is administered in this division. The goal of "Loving Steps" is to reduce health disparities within the African American population in order to improve birth outcomes. Virginia's federally funded Healthy Start Initiative, which began in 1997, currently serves two urban areas, Norfolk and Petersburg, and one rural area, Westmoreland County. These communities were chosen because of their higher than average infant mortality and low birth weight rate along with a high rate of births to teens and their high rates of poverty and other risk factors. Loving Steps provides at-risk pregnant women, inter-conceptual women and at risk infants and toddlers with case management, health education, inter-conceptual care, and perinatal depression screening using the Edinburgh Postnatal Depression Scale. Loving Steps also works closely with the Resource Mothers program, the Regional Perinatal Councils and the Fetal/Infant Mortality Review (FIMR) program to improve birth outcomes. The Sickle Cell program coordinates the follow-up of newly diagnosed newborns with sickle cell disease and includes public and family education, testing and counseling regarding the disease. In addition, DWIH staff participates in the Maternal Mortality Review Team that is located in the Virginia Department of Health's Office of the Chief Medical Examiner.

The Division of Child and Adolescent Health's (DCAH) mission is to give children, including children with special health care needs, a healthy start in life and help them maintain good health

in the future. Joanne Boise, R.N., M.S.P.H., serves as the division director. The DCAH mission is accomplished through assessing health data, identifying resources, informing the public about child and adolescent health issues, assisting policy makers, supporting private and public health care providers, developing and implementing programs and information systems, identifying resources, providing clinical consultation and educational activities, and developing and distributing guidelines and educational materials. Programs administered in the division include the Teen Pregnancy Prevention Initiative, Newborn Screening Services, Early Hearing Detection and Intervention Program, Virginia Congenital Anomalies Reporting and Education System (birth defects registry), Early Childhood and School Age Health, Child Development Clinics, Bleeding Disorders Program, and Care Connection for Children. Staff co-lead Bright Futures Virginia, most recently overseeing the development of the Bright Futures-based web portal for parents, www.healthyfuturesva.com. In addition, division staff participates on the Part C Interagency Coordinating Council, the State and Local Advisory Team for the Comprehensive Services Administration, and the Foster Care Health Plan Work Group. The Childhood Lead Poisoning Prevention program originally was housed in the DCAH, but was transferred to the Office of Environmental Health within VDH. Collaborative efforts relating to lead poisoning prevention continue between the Office of Environmental Health and the DCAH.

The Children with Special Health Care Needs (CSHCN) program is located within the DCAH and consists of Care Connection for Children, the Child Development clinics and the Bleeding Disorders Program. Nancy Bullock, RN, M.P.H is the director of the CSHCN program. The Care Connection for Children program is the statewide network of centers of excellence for children with special health care needs (CSHCN) that provides leadership in the enhancement of specialty medical services; care coordination; medical insurance benefits evaluation and coordination; management of the CSHCN Pool of Funds: information and referral to CSHCN resources; family-to-family support; and training and consultation with community providers on CSHCN issues. The centers are geographically located to serve the entire state. Virginia resident children ages birth to 21 years are eligible for services if their disorder has a physical basis; has lasted or is expected to last for at least 12 months; and either requires health care and ancillary services over and above the usual for the child's age, or special ongoing treatments, interventions, or accommodation at home or school, or limits function in comparison to healthy age children; or is dependent on medications, special diet, medical technology, assistive devices or personal assistance. A limited amount of money (CSHCN Pool of Funds) is available to assist children who are uninsured or underinsured. This assistance is limited to families with a gross income at or below 300% of the Federal Poverty Level.

The Child Development Clinics, also managed by the Division of Child and Adolescent Health, is a specialized program for children and adolescents suspected of having developmental and behavioral disorders such as developmental delays, disorders of attention and hyperactivity, learning problems, mental retardation, and/or emotional and behavioral concerns. A professional team consisting of a pediatrician or nurse practitioner, nurse, social worker, educational consultant, and psychologist provide diagnostic assessment, treatment planning, follow-up care coordination and referral. Interagency coordination is provided with the Virginia Department of Education, local health departments, Part C early intervention services, mental health clinics, Head Start programs, Department of Social Services and others. Eligibility is limited to Virginia resident children under the age of 21 years. A sliding scale charge is based on income level and family size.

The Virginia Bleeding Disorders Program, a legislatively enacted program, was established to serve as a "safety net" for persons with inherited bleeding disorders. The Virginia Bleeding Disorders Program provides insurance case management that assists persons in considering their options and completing the insurance application and enrollment process. The program provides assistance in accessing specialty health care services and establishing a medical home, care coordination, information and referral, family-to-family support, training and technical assistance for community providers, transition from child to adult oriented health care system,

and the promotion of quality assurance. A limited amount of money is also available to assist uninsured and underinsured persons to receive care that they would otherwise not be able to afford. Bleeding disorder centers are located in Norfolk, Fairfax, Richmond and Charlottesville. The Virginia Hemophilia Advisory Board, consisting of governor appointed members, provides a mechanism to address the statewide needs of persons with inherited bleeding disorders.

The Division of Dental Health's primary goal is to prevent dental disease. Karen Day, D.D.S., M.P.H., is the division director. Dental services are provided in approximately half of Virginia's localities to pre-school and school age children who meet eligibility requirements through the local health departments. Eligibility for these services may be determined by school lunch status and/or family income. Dental services are available at health department clinics or at dental trailers placed on school property. Adult care is available on a limited basis in certain localities. The Division of Dental Health also supports community fluoridation by monitoring water systems for compliance in conjunction with Virginia Department of Health Office of Drinking Water, reporting water system data to the Center's for Disease Control and Prevention Water Fluoridation Reporting System (WFRS), providing information about the benefits of water fluoridation to citizens and communities, and by providing grant funding for communities to start or upgrade fluoridation equipment. The division also engages in epidemiological studies to determine the level of need for dental care. Most recently 8,000 school children were surveyed to document the level of decay, fillings, missing teeth and dental sealants.

In the past the Division of Dental Health supported the School Fluoride Mouthrinse Program and provided funding for fluoride mouthrinse supplies, training on implementing school mouthrinse programs, and brochures and educational information regarding the program. This program was eliminated this year as a result of budget reductions. The division's "Bright Smiles for Babies" Program targets children from birth to three years old at highest risk for dental decay. The goal of the program is to increase early recognition of disease and provide prevention through training dental and non-dental health professionals on oral health education and anticipatory guidance, screening and risk assessment and fluoride varnish application. The division recently expanded the Bright Smiles for Babies program to provide training, presentations, educational materials and resources for parents/caregivers and providers regarding oral health for children with special health care needs. In the past it has been difficult for parents to find dentists who provide care to CSHCN. The Division of Dental Health surveyed Virginia's dentist in order to develop a provider directory. As a result of the responses received from the dentists, an interactive provider directory is now available to families of CSHCN on the VDH website. http://www.vahealth.org/dental/dentaldirectory/QuickSearch.aspx

Funding for both the Dental Scholarship Program and the Dental Loan Repayment Program that provides funding for dental students with repayment through service in underserved areas was recently eliminated due to the economic turndown that has resulted in state budget reductions.

The Director of the Division of Nutrition, Physical Activity and Food Programs (formerly the Division of WIC and Community Nutrition Services) is Donna Seward, FACHE. The division administers the Virginia Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serving approximately 160,000 low to moderate income families through local health departments and mobile clinics. The WIC program goal is to enable women to deliver and nurture healthy children. The WIC program includes outreach and education components and encourages breastfeeding for new mothers. Effective October 1, 2010, the division will take over the administration of two additional food programs, the Child and Adult Care Food Program and the Summer Food Service Program. The division implemented CHAMPION, the Commonwealth's Health Approach and Mobilization Plan for Inactivity, Obesity, and Nutrition to address the increase in obesity rates statewide. The program uses a community driven approach by providing communities with evidence based program models, technical assistance and limited grant funds to implement the community initiative. Grants are available statewide and include funding for programs and strategies that target health behavior, policy, and environmental change. Specifically, funding is provided for programs to address nutrition education, physical activity, and

policy change in preschool settings, for parents of adolescents, to create active aging environments, promote worksite wellness, and support breastfeeding promotion.

The Statewide Breastfeeding Advisory Committee is comprised of influential Virginians representing various organizations. The member organizations represent a wide variety of practice settings and create a multidisciplinary membership. They work in partnership with the Virginia Department of Health's Division of Women's and Infants' Health and the Division of Nutrition, Physical Activity, and Food Programs to aid in increasing the incidence and duration of breastfeeding among mothers. Representatives include such organizations as the American College of Nurse Midwives, the American Dietetic Association, universities, La Leche League, Medela, the Virginia Nurses Association and others.

The Division of Injury and Violence Prevention's primary goal is to prevent injuries, suicide and violence. Erima Fobbs, B.SC., MPH is the director. To reduce the impact of injury and violence, the division engages in injury assessment, the development and promotion of prevention programs and policies, training and community education. The division also promotes and disseminates safety devices, conducts public information campaigns and funds local prevention projects. The division works collaboratively with health, education, social service and mental health providers, law enforcement, fire and EMS providers, and a variety of other community groups across the Commonwealth. The division's unintentional injury programs address home, school and transportation safety including child passenger safety, infant safety, traumatic brain injury, fire and drowning prevention. The division's violence prevention programs address sexual violence, suicide, youth violence, including bullying, and intimate partner violence.

The goal of the Chronic Disease Prevention and Control Division is to reduce the human and financial burden of chronic diseases, which are the leading causes of death in Virginia. The division director is Ramona Schaeffer, M.S.Ed, C.H.E.S. The division's prevention and control efforts include the development of programs and policies, training and state action plans that outline goals and strategies for business, civic and governmental agencies to control chronic diseases such as arthritis, asthma, cancer, diabetes, or heart disease and stroke. The division focuses on promoting evidence-based interventions, monitoring the burden of chronic diseases in the state, developing partnerships with other state and local agencies, and evaluating outcomes of projects interventions. Other division efforts include outreach to promote health for persons living with disabilities and prevention of secondary chronic diseases, and to modify risk behaviors such as tobacco use, lack of physical activity and poor nutrition, which are major contributing factors leading to chronic diseases. The division manages numerous categorical CDC grants including the CDC funded Tobacco Use Control Program (TUCP). In addition, the Virginia Cancer Registry is located within this division.

The Office of Family Health Services is responsible for addressing several federal (e.g., Title V and Title X) and state mandates for improving the health of women and children. State statues relevant to the Virginia's Title V program authority are included in the attachment to this section.

Culturally Competent Care

The OFHS is committed to providing culturally competent care for the MCH populations. This is being accomplished in a number of ways. First data is collected and analyzed according to different race and ethnic categories and used to inform program development including the targeting of resources. The race and ethnic categories have been standardized across data collection systems that are housed in the OFHS DataMart. OFHS also collaborates with culturally diverse community groups to ensure their representation in needs assessment, program planning and evaluation. For example, findings from five minority focus groups was utilized in the development of web-based training for providers on identifying and addressing perinatal depression. Efforts are made to ensure that health promotion materials are culturally appropriate and translated into appropriate languages, with Spanish being the most prevalent. News releases regarding public health issues are placed in newspapers that are read in different racial and ethnic communities. OFHS staff participate in cultural competency trainings. For example,

the Care Connection for Children staff participated in two days of training on cultural competency provided by the Georgetown University Center for Cultural competency. A recent in-service training on racial disparities sponsored by the Office of Health Policy (OHP) was attended by a number of Title V staff. Contracts with the district health departments for maternal and child health services include a requirement that care must be provided in a culturally competent manner. To assure a representative OFHS workforce, position vacancies are posted in newspapers and on websites that are viewed by different racial and ethnic communities.

VDH contracts with Language Services Associates (LSA) for telephone interpreting and document translating. LSA offers interpreting and translating services in 212 languages, including all of the 50+ languages specifically required by VDH in their Request for Proposals. The Virginia Department of Health's Office of Minority Health and Health Policy developed a website that provides resources to assist health care providers to better meet the needs of the Commonwealth's diverse populations. The resources include training materials, research articles, assessment tools and a calendar of events. The website also provides language resources that include a list of commonly used clinical phrases in both English and Spanish. OHFS continues to work with the OHP to develop additional resources that specifically target the diverse MCH population. The website is available at http://clasactVirginia.vdh.virginia.gov

In 1990, Virginia's State Health Commissioner created the Minority Health Advisory Committee (MHAC) to ensure that the health priorities and health concerns of Virginia's minority populations were adequately addressed by the Virginia Department of Health. The MHAC includes appointed representatives from local, state and federal public health agencies, University of Virginia's Center for Public Service, Virginia Commonwealth University's Department of Pharmaceuticals, Norfolk State University's Department of Political Science and Economics, Baptist General Convention of Virginia, Vietnamese Resettlement Association, Powhatan Society, Hispanic Committee of Virginia, private health care providers and consumers. MHAC's membership is intended to be representative of Virginia's minority and underserved populations. Their work includes advising and making recommendations to the VDH Commissioner, identifying limitations associated with existing laws, regulations, programs and services, identifying and reviewing health promotion and disease prevention strategies and supporting policies and legislation to improve accessibility and acceptability of health services.

Legislation requested by former Governor Kaine and adopted by the 2007 General Assembly gives greater emphasis on minority health issues by directing the State Health Commissioner to designate a senior staff member who is a licensed physician to direct the Department's minority health efforts. Michael Royster, M.D., M.P.H. has been appointed to this position and serves as the Director of Minority Health and Public Health Policy for the Department of Health.

An attachment is included in this section.

C. Organizational Structure

The Virginia Title V program is housed within the Virginia Department of Health, one of twelve agencies within the cabinet level Health and Human Resources Secretariat. In January 2010, the newly elected Governor, Bob McDonnell, appointed Dr. Bill Hazel as the Secretary of Health and Human Resources. Dr. Hazel is involved with numerous healthcare related associations and is a board certified orthopedic surgeon. Dr. Karen Remley, appointed by the previous governor Tim Kaine, has been reappointed as the State Health Commissioner. The Virginia Department of Health includes four deputy commissioners that provide oversight for Community Health Services; Public Health and Preparedness; Public Health; and Administration.

The Virginia Department of Health (VDH) is mandated by the Code of Virginia to "administer and provide a comprehensive program of preventive, curative, restorative and environmental health services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research,

and abate hazards and nuisances to the health and environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth." In carrying out these responsibilities, VDH, in conjunction with the Board of Health, promulgates and enforces over 60 sets of regulations and manages over 70 federal and state grants.

In 1947, the Virginia General Assembly passed legislation requiring "each county and city to establish and maintain a local health department." Then in 1954, the Virginia General Assembly passed legislation that permitted the Department to organize the local health departments into 35 health districts which now include 119 local health departments. The local health departments are jointly funded by the state and the cities and counties that they serve. The local funding is based on the ability to pay with some localities contributing as little as 18% while others contribute as much as 45% match to state dollars. Each health district has a cooperative agreement that delineates the mandated basic health services that each district must provide and any additional services based on need and available funds. The General Assembly has authorized the local governments in Arlington and Fairfax to manage their own health departments and they operate under a contractual agreement with the state.

Section 32.1-77 of the Code of Virginia specifically addresses VDH's authorization to prepare and submit to the U.S. Department of Health and Human Services the state Title V plan for maternal and child health services and services for children with special health care needs. The Commissioner of Health is authorized to administer the plan and expend the Title V funds.

Within VDH's central office, the Title V Block Grant is managed by the Office of Family Health Services (OFHS). Dr. David Suttle, the OFHS director and also the Title V director retired on April 30, 2010 and Dr. Diane Helentjaris was appointed as OFHS director on May 25, 2010. Dr. Helentjaris reports directly to the Chief Deputy Commissioner for Public Health. Other offices under the direction of the Deputy for Public Health include Drinking Water, Epidemiology and Environmental Health.

The administration of the Block Grant resides at the OFHS office level while divisions within the Office have specific responsibility for carrying out MCH programs. The divisions include Dental Health, Women's and Infants' Health, Chronic Disease Prevention and Control, Child and Adolescent Health, Nutrition, Physical Activity and Food Programs and Injury and Violence Prevention. The CSHCN program resides within the Office's Division of Child and Adolescent Health.

The mission of the OFHS is to provide the leadership, expertise and resources that enable all Virginia residents to reach and maintain their optimum level of health and well-being throughout life. In order to accomplish this, the office is organized into the Director's office and six divisions. The Director's office includes crosscutting functions which are comprised of the Business Unit and the Policy and Assessment Unit. The Business Unit includes budgeting, accounting, contracting, grants management, procurement and human resource functions. The Policy and Assessment Unit (PAU) mission is to assure that valid, reliable, and timely health information is available to direct effective policies and actions. More specifically the PAU provides leadership in the development and management of the Title V and the Preventive Health and Health Services (PHHS) block grants; manages special information technology projects; coordinates the legislative review process; manages the Behavior Risk Factor Surveillance System Survey (BRFSS), the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Virginia Youth Survey (VYS), the Virginia Assessment Initaitive VAIP) and the State Systems Development Initiative (SSDI); creates and maintains a standard electronic repository of OFHS health-related data including linked datasets; develops and provides web-based tools to disseminate health information for community health assessments; and provides training and consultation to OFHS staff regarding epidemiologic practices, statistical analysis and program evaluation.

Title V funds are provided annually to the 35 health districts to support maternal and child health services. The district funding levels are based on an estimate of the proportion of low income

(200% FPL) births within each of the districts. A total of approximately $3.5 million is annually provided to the districts. Currently district Title V funding addresses the following areas: perinatal services, dental services, injury prevention, obesity prevention, infant mortality, breastfeeding, teen pregnancy prevention, child care safety, and access to care.

Organizational charts for Virginia State Government, the Virginia Department of Health and the Office of Family Health Services are attached.

An attachment is included in this section.

D. Other MCH Capacity

Virginia's MCH Program, comprised of staff in the Office of Family Health Services, includes a highly skilled and diverse team of public health professionals representing a variety of disciplines. Thirty-six and a half full-time equivalent positions (FTEs) in the OFHS are funded by the MCH Block Grant. In addition, numerous district health department staff, including physicians, public health nurses, and support staff are also supported in part by Title V funds.

Senior level MCH staff in the Office of Family Health Services include the following:

Diane Helentjaris, M.D., M.P.H. was appointed as the Director of the Office of Family Health Services effective May 25, 2010 following the retirement of Dr. David Suttle. Dr. Helentjaris previously served as the director of the Loudoun Health District and the Lord Fairfax Health District, the Richmond City Health Department's deputy director, director for the H1N1 Response, the Deputy State Epidemologist, and Deputy Director of the Office of Epidemiology.

Janice M. Hicks, Ph.D. has served as the Policy and Assessment Director since 1997 and as the Office of Family Health Services' Senior Policy Analyst since 1994. She has over 20 years of experience in planning, evaluation and legislative analysis. Dr. Hicks also has experience in teaching college level courses in Sociology, Research Methods, Evaluation, Social Theory, Family, and Criminology/Juvenile Delinquency. She also serves as an adjunct faculty member in the Virginia Commonwealth University's Department of Epidemiology and Community Health.

The Policy and Assessment Unit includes the grants coordinator (Robin Buskey), the State Systems Development Initiative (SSDI) Coordinator (Caroline Stampfel), the MCH Epidemiologist (Derek Chapman), the Behavior Risk Factor Surveillance System Coordinator (Susan Spain), a Senior Health Policy Analyst (Kim Barnes) who continues to serve as the agency HIPAA compliance officer, the OFHS liaison to the Department of Medical Assistance Services on issues involving Medicaid and FAMIS and participates in special projects that include business intelligence applications, emergency preparedness and health information exchange. Marilyn Wenner serves as the PRAMS Coordinator, Shanee Harmon serves as the Virginia Youth Survey Coordinator (YRBS) and Michelle White is the Virginia Assessment Initiative Coordinator.

Karen Day, D.D.S., M.S., M.P.H., has served in her current capacity as Director of the Division of Dental Health with the Virginia Department of Health (VDH) since 1996. Prior to this position she served as Community Water Fluoridation Coordinator for the Division for three years and as a public health dentist for fifteen years. Dr. Day has taught graduate and undergraduate courses at Virginia Commonwealth University including biology, oral epidemiology, principals of public health and public health dentistry.

Nancy R. Bullock, R.N., M.P.H., the CSHCN Program Director, has over 40 years of experience in public health in Virginia. She served as a nurse consultant, program and division director at the state level and at the local level as a public health nurse and nurse manager. She has been the director of the CSHCN Program since 1991.

Joan Corder-Mabe, R.N.C., M.S., W.H.N.P., was selected as the Director for the Division of Women's and Infants' Health in 2001. Previously she served as the perinatal nurse consultant and the Acting Division Director. She is responsible for programs including the Title X Family Planning, the Virginia Healthy Start Initiative, the CDC Breast and Cervical Cancer Early Detection Program, Partners in Prevention, the Resource Mothers Program, Women's Health, the Regional Perinatal Councils, and the Comprehensive Sickle Cell Program. She and the division staff also provide consultation and technical assistance to the local health departments serving perinatal clients.

Joanne S. Boise has served as Director of the Division of Child and Adolescent Health since June 2001. With a background in nursing, she holds an M.S.P.H. in health policy and administration. Prior to joining VDH, Ms. Boise spent fifteen years in the managed care industry working locally and nationally; she has held positions in health policy, HMO operations, quality improvement, utilization management, and network management. She oversees the VDH newborn screening programs, CSHCN programs, early and school age childhood initiatives, and teen pregnancy prevention. She co-leads the Bright Futures Virginia effort and works closely with the Virginia Chapter of the American Academy of Pediatrics on a number of projects to improve well-child care. She was a member of Virginia's Core Team for the ABCD Screening Academy and continues to champion the medical home, routine developmental screening as part of well child care, and prompt referral to early intervention.

Donna Seward, B.S., has served in her current capacity as the Director of the Nutrition, Physical Activity and Food Programs (formerly the Division of WIC and Community Nutrition Services) since April 2000. She is responsible for the management of Virginia's WIC program and two new food programs -- the Child and Adult Care Food Program and the Summer Food Service Program. She also has responsibility for CHAMPION, the obesity prevention initiative. From 1976 to 2000 she served as the WIC Director at the local level in Texas. Her educational background is in health care management.

Erima S. Fobbs, B.Sc., MPH, is the Director of the Division of Injury and Violence Prevention (DIVP). Her MPH included a concentration on Epidemiology and Health Services Administration. She has over 22 years of experience in prevention and has directed Virginia's statewide injury and violence prevention program since 1994. She has also taught courses on the Epidemiology and Prevention of Intentional Injury as an adjunct assistant professor at MCV/VCU department of Preventive Medicine and Public Health and is a certified suicide prevention and bullying prevention program trainer.

In the fall of 2004, OFHS contracted with the Virginia Commonwealth University's Public Health program to hire a faculty level MCH epidemiologist. Derek Chapman, Ph.D. was hired in this jointly appointed position that is supported in part by SSDI funds. Dr. Chapman previously served as the Director of Research at the Tennessee Department of Health and has a number of years of experience working with MCH data. The joint appointment of Dr. Chapman provides an opportunity for greater collaboration between the OFHS and the VCU Public Health program and has resulted in benefits for both OFHS and the University through increased opportunities for grants, student internships, technical assistance and publications. Dr. Chapman works closely with the division level epidemiologists to establish greater access to data including the development of the OFHS Data Mart, a repository of data selected and organized to support the surveillance and evaluation needs of the OFHS epidemiologists. The Data Mart consists of key datasets that are cleaned, aggregated, and standardized to enable automation of regular ongoing surveillance reporting and analysis. The data are used by all divisions for surveillance, assessment, program planning, grant applications, and grant reporting.

The OFHS Policy and Assessment Unit has taken advantage of the Council of State and Territorial Epidemiologists' (CSTE) 2-year fellowship program. Caroline Stampfel, the first CSTE fellow placed in the OFHS, was hired as an OFHS MCH epidemiologist following her fellowship.

The second fellow, Andrea Alvarez, completed her CSTE fellowship and was hired by the VDH Office of Epidemiology. A third CSTE fellow will join the Policy and Assessment Unit in August 2010 for a 2-year fellowship.

The OFHS Policy and Assessment Unit has also hosted a number of MCHB Graduate Student Internship Program (GSIP) students over the years. Currently, a graduate student from the University of North Carolina is serving as a GSIP intern for the summer.

In order to continue to increase our capacity and to better use our available resources, the Policy and Assessment Unit has created a team to review all research and evaluation proposals. The review team, made up of Policy and Assessment staff as well as research-related representatives from the Divisions, work closely with Division staff to review plans for research and evaluation activities to be completed in-house or through a contractor.

The benefits of this new review process include:

A decrease in the duplication of research and evaluation activities that occur across the OFHS divisions;
An increase in the amount of funding available for program activities and a decrease in the amount of funding spent on research and evaluation activities;
An increase in the research and evaluation capacity of OFHS program staff;
An increase in collaboration across the OFHS divisions;
An increase in the identification of qualified contractors;
An increase in OFHS staff support in developing their research activities; and
An increase in oversight of all research and evaluation activities to ensure that work that is contracted out is reasonable, cost-effective, and necessary.

Family Involvement

OFHS provides a number of opportunities for family input into the MCH and CSHCN programs. A parent feedback survey is used to assess the services provided by Care Connection for Children centers, Bleeding Disorders Program, and the Child Development Clinics. The Care Connection for Children (CCC) centers employ parents of CSHCN as parent coordinators. In addition, the centers have contractual relationships with the coordinators of Parent to Parent, Family to Family and Medical Home Plus to provide outreach, support, mentorship, and training to parents. They have assisted the Care Connection for Children centers in establishing their family-to-family support services. Parents from Parent to Parent provided input into Virginia's state CSHCN plan to meet the Healthy People 2010 goals. Parent focus groups have provided input for various MCH related programs. Family representatives serve on the Regional Perinatal Councils, the Hemophilia Advisory Board, the Fetal Alcohol Spectrum Disorder Task Force, the Virginia Early Hearing Detection and Intervention Advisory Committee and its Parent Subcommittee, and the Virginia Genetics Advisory Committee. OFHS staff also participates in a number of organizations with families such as the Virginia Chapter of the Hemophilia Foundation, Spina Bifida Foundation, Cystic Fibrosis Foundation, Virginia SIDS Alliance, Virginia Parents Against Lead, and the Virginia Congress of Parents and Teachers.

The Family to Family Health Information and Education Center (F2F), is based within the VCU Partnership for People with Disabilities, recognized by the federal Administration on Developmental Disabilities as a university center for excellence in developmental disabilities. The Center is a collaborative effort among three organizations: Center for Family Involvement at the Partnership for People with Disabilities, Parent to parent of Virginia, and Medical Home Plus. Each of these organizations has parent staff that have children with special health care needs. The Center for Family Involvement and Support is a collaborative effort between the Partnership and the Virginia Department of Education to implement activities that promote education and advocacy for parents and families of children with disabilities, birth through 22 years of age. The

activities of the Center for Family Involvement and Support address a need for parents and families to have adequate information, training, materials and supports to understand, participate in and guide decision making about programs and services that affect them and their children with disabilities

Dana Yarbrough, Executive Director of Parent to Parent of Virginia serves as Virginia's family liaison delegate to the Association of Maternal and Child Health Programs (AMCHP). Dana and Parent to Parent of Virginia currently work closely with Virginia's CSHCN program, Care Connection for Children.

E. State Agency Coordination

In Virginia, state health and human services agencies are organized under the jurisdiction of the cabinet level Secretary of Health and Human Resources who is appointed by the governor. The major health and human services agencies include the Department of Health, the Department of Medical Assistance Services, the Department of Behavioral Health and Developmental Services (formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services), and the Department of Social Services. The Departments of Juvenile Justice and Corrections, and the Department of Education are located under different cabinet secretaries. The Health and Human Resources Secretariat also includes a number of advisory boards that provide opportunities for coordination including the Governor's Advisory Board on Child Abuse and Neglect, the Child Day Care Council and the Governor's Substance Abuse Services Council.

There are also ongoing opportunities to work with Virginia's health education programs and universities. For example, OFHS contracts with the Virginia Commonwealth University's (VCU) Department of Preventive Medicine and Community Health for the services of a faculty level MCH epidemiologist to work within the OFHS. A number of the state universities, including VCU, Virginia Tech, Eastern Virginia Medical School, George Mason University, James Madison University and the University of Virginia have been involved in activities such as trainings, including web-based training, research and report writing, web development and evaluations of programs. OFHS has contracts with university medical centers to provide child development services and CSHCN services through Care Connection for Children. Other contracts with University medical centers include sickle cell, genetic consultation/services and bleeding disorder services.

The Department of Medical Assistance Services (DMAS) continues to bring the public and private sector together to address issues related to service delivery for mothers and children. The Child Health Insurance Advisory Committee (CHIPAC) has representatives from state agencies, private industries, providers and consumers. An OFHS staff is a member of this committee.

An interagency agreement exists between VDH and DMAS for the coordination of Titles V and XIX services. The assignments of responsibilities as stated in the agreement are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory function and mission of VDH. The agreement has been modified to include a Business Associate Agreement for the purpose of data sharing. The current data sharing projects involve the exchange of blood-lead testing results, eligibility information and decedent information.

The interagency agreement also includes coordination of Medicaid and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The agreement includes mechanisms to assist eligible women and infants to obtain Medicaid coverage and WIC benefits. In addition, the Maternal Outreach Program - a cooperative agreement which expands the VDH Resource Mothers Program - supports the coordination of care and services available under Title V and Title XIX by the identification of pregnant teenagers who are eligible for Medicaid and assisting

them with their eligibility applications.

DMAS directs the EPSDT Program and collaborates with the VDH and DSS on specific components of the program. VDH interagency responsibilities include, when appropriate, (1) providing consultation on developing subsystem and data collection modifications and (2) collaborating on (a) modifying the Virginia EPSDT Periodicity Schedule based on Bright Futures, (b) developing materials to be included in the EPSDT Supplemental Medicaid Manual and other provider notices as may be required, (c) providing EPSDT educational activities targeted to local health departments, (d) implementing strategies that will increase the number of EPSDT screenings, and (e) making available current EPSDT program information and materials that are needed to communicate information to local health department patients.

The Department of Medical Assistance Services, in collaboration with the Departments of Health and Social Services, worked together to link high-risk pregnant women and infants to Baby Care. The program services include outreach and care coordination, education, counseling on nutrition, parenting and smoking cessation and follow-up and monitoring. This program has demonstrated significant improvements in birth outcomes. OFHS staff participate in trainings with DMAS staff on such topics as Bright Futures and EPSDT.

The OFHS contracts with the six regional sites that make up the Statewide Human Services Information and Referral System, administered by the Virginia Department of Social Services, for information and referral services for the MCH Helpline. The system can be accessed from any location in the Commonwealth by dialing "211." The system has been helping Virginians since 1974. This number also serves as the state number for the National Baby Line to provide information and referral for prenatal care. Data documenting maternal and child health related service calls are collected and reported to the OFHS quarterly as required by the contract. This information provides data for future needs assessments and program. Copies of the most recent contracts are on file in the OFHS.

Children with Special Health Care Needs

The Division of Child and Adolescent Health's Care Connection for Children (CCC) and the Child Development Clinic Services (CDC) programs have provider agreements with the Department of Medical Assistance Services. Copies of these agreements are on file in the Office of Family Health Services and are reviewed periodically. The CCC and CDC programs bill Medicaid for physician, laboratory, psychological, and hearing services. In the past, DCAH worked with DMAS to revise several state-specific reimbursement codes used for CSHCN.

A collaborative relationship has also been established between the Care Connection for Children Program, the Social Security Administration Field Office in Virginia and the Disability Determination Services in the Virginia Department of Rehabilitative Services to enhance each program's roles and responsibilities pertaining to the SSI beneficiaries. Strategies for publicizing each program, facilitating application for benefits and services, expediting referrals, acquisition of medical and other evidence, and reciprocal training about programs available to children with disabilities are continuing.

An interagency agreement exists between VDH and the Department of Education (DOE) for the inclusion of educational consultants as members of the interdisciplinary teams in CDC and CCC centers. The consultants provide liaison services among the clinics and centers, the children's families and local education agencies serving the children. Duties include administering and interpreting developmental and/or educational evaluations; identifying learning styles, strengths, and weaknesses; recommending educational strategies and modifications; consulting with school personnel regarding modifications in school programs; monitoring and reevaluating progress of the children; and providing staff development. DOE provides the position and funding and contracts with a local school division to provide the supervision and fiscal management of the

position. VDH provides the housing and secretarial support and participates in the evaluation of the educational consultants.

The Title V program has established and maintains ongoing interagency collaboration for systems building in some defined areas. The Title V program collaborates with DOE to develop and maintain guidelines for school health services for CSHCN, such as the First Aid Guide for School Emergencies and the Guidelines for Specialized Health Care Procedures. VDH and the American Lung Association have established the Virginia Asthma Coalition to assess needs, share information, and collaborate on the use of available resources.

Other Collaborative Agreements

The Commissioner of the Department of Health serves on the Early Intervention Agencies Committee that was established in 1992 through Section 2.1-760-768 of the Code of Virginia to ensure the implementation of a comprehensive system of early intervention services for infants and toddlers. A representative from the DCAH is an active participant on the Virginia Interagency Coordinating Council (VICC). At the local level, professional staff from the health departments and the Child Development Clinics serve on the local interagency coordinating councils.

The Comprehensive Services Act for At-Risk Youth and Families provides a comprehensive, coordinated, family-focused, child-centered, and community-based service system for emotionally and/or behaviorally disturbed youth and their families throughout Virginia. One representative from VDH/Title V serves on the State Executive Council and another serves on the State and Local Advisory Team (SLAT). Other representatives from the state and local health departments serve on workgroups. Local health departments and/or Child Development Clinic representatives may serve on local community policy and management teams and family assessment and planning teams.

The Title V funded programs are also coordinated with other health department programs that serve a common population group including Immunization, STD/AIDS, and Emergency Medical Services. Immunizations are provided as part of local health department services as are family planning and well-child services. Screening and treatment for STDs are provided in family planning clinics. Family planning, prenatal, and well-child patients may be referred to health department dental services.

OFHS works closely with the Department of Education to implement the Virginia Youth Survey (YRBS). The OFHS Dental Division also works closely with local school districts, local schools and WIC programs to provide dental preventive dental services and surveillance.

The Breastfeeding Advisory Committee is comprised of influential Virginians representing various organizations. The member organizations represent a variety of practice settings and create a multidisciplinary membership. They work in partnership with the OFHS to aid in increasing the incidence and duration of breastfeeding among mothers. Representatives include such organizations as the American College of Nurse Midwives, the American Dietetic Association, universities, La Leche League, Medela, the Virginia Nurses Association and others.

The Virginia Chapter of the March of Dimes (MOD) continues as a significant partner in advocating for women and infants. The MOD has worked closely with Virginia's Health Start program and with the home visiting programs across the state.

The Commissioner's Infant Mortality Work Group, staffed by OFHS, involves members of the community who have credibility and can influence local families. In addition to medical/health professionals, a wide range of community members such as local educators, civic and business officials, the NAACP, and the AARP are included as members.

The Commissioner's Work Group on Obesity prevention and Control is a multidisciplinary group

formed to provide leadership and structure in obesity prevention efforts in the Commonwealth. Guidance from the work group endorsed VDH's obesity prevention initiative by officially facilitating efforts towards producing the final CHAMPION Obesity Prevention Plan.

Intra-agency and interagency collaboration will continue with the above mentioned agencies and others such as, WIC, the Office of Primary Care and Rural Health, Title X -- Federal Family Planning Program, the Commission on Youth, the Virginia Commission on Health Care, the VDH Office of Minority Health and Public Health Policy, the Virginia Community Healthcare Association (formerly the Virginia Primary Care Association), and the Virginia Hospital and Health Care Foundation. In addition, Title V staff will continue to support community-based organizations that have been working to improve the health of the MCH population including organizations such as the Virginia Perinatal Association, the Virginia Association of School Nurses, the Virginia Chapter of the March of Dimes and numerous single disease oriented voluntary organizations.

Title V staff will continue to represent the MCH interests on numerous interagency councils, task forces and committees such as the Governor's Office for Substance Abuse Prevention (GOSAP), the Governor's Council on Substance Abuse Services, and the Governor's Advisory Board on Child Abuse and Neglect, and the Child and Family Behavioral Health Policy and Planning Committee. Title V staff represents the VDH on the legislatively mandated Children's Health Insurance Program Advisory Committee (CHIPAC).

To facilitate the work of the Secretary of Health and Human Resources, the Title V program staff will continue to provide analysis and recommendations to the Governor on legislation before the General Assembly that will directly affect VDH programs and women's and children's health in Virginia. OFHS staff will continue to review and comment on legislation, regulations, and standards of other state agencies from a maternal and child health perspective.

Copies of all interagency agreements are maintained on file in the Office of Family Health Services and are reviewed and amended as required.

F. Health Systems Capacity Indicators

Introduction

Health system Capacity Indicators provide additional surveillance measures that contribute to the development and targeting of services and the evaluation of MCH-related policies and programs. These indicators also provide guidance to collaborative efforts with other agencies and organizations to improve access to quality and timely health care.

Over the past five years improvement in access to surveillance data on a regular basis has been a priority for the OFHS. As a result of funding from the State Systems Development Initiative Grant (SSDI) to support a MCH Epidemiologist, surveillance data is now updated on a regular basis. A Memorandum of Agreement with Vital Records and the Center for Health Statistics provides all OFHS staff access to complete statistical data files on birth, death, fetal death, linked birth-infant death and intentional terminations of pregnancy. Through the development of the OFHS Data Mart, OFHS staff has access to standardized 1995-2008 vital records data and 1996-2008 hospital discharge data. In addition, the Behavior Risk Factor Surveillance System Survey (BRFSS)data, the Pregnancy Risk Assessment Monitoring System (PRAMS) data and the Virginia Youth Survey are also available. Provisional data (monthly births and deaths; quarterly hospital discharges and Census data are also indluced in the Data Mart.

A five-year CDC Assessment Initiative grant funds enahncements in community health assessment in the central office and health districts.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	32.2	31.6	30.8	28.0	25.8
Numerator	1653	1607	1597	1463	
Denominator	513018	508965	518410	522672	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data for 2009 not yet available. Entry is an estimate based on trend.

Notes - 2008
2008 Virginia hospital discharge data. Denominator from 2008 NCHS population estimates.

Notes - 2007
2007 Virginia hospital discharge data. Denominator from 2007 NCHS population estimates.

An attachment is included in this section.

Narrative:
Asthma is considered an ambulatory sensitive condition for which hospitalizations can be largely prevented with consistent, available ambulatory care and adherence to treatment/self-care protocols. Hospital admissions may indicate access issues such as lack of insurance or few other options for service or the presence of social issues that may influence patient/family care such as homelessness or inconsistent caregivers. Over the years there has been a significant steady decrease in the rate of asthma related hospitalizations for children age 5 and under. In 1998 39.7 /10,000 children were hospitalized for asthma while the most recent provisional rate (2008) is 25.8/10,000. If hospitalizations for this condition had been prevented substantial saving would have resulted. However, the available data does not present a complete picture of the impact of asthma since the visits to emergency rooms is not captured unless the visit results in hospitalization. There are critical gaps in asthma related data. For example, Virginia does not have data on the number of children with asthma, where they are being treated, and if their treatment is in accordance with national guidelines. We know that asthma causes many missed school and work days, but do not have data to track these additional burdens for those living with asthma.

The Virginia Asthma Coalition (VAC) consisting of seven regional coalitions works to improve asthma in the communities by promoting asthma awareness and prevention, asthma education, and the dissemination of asthma data. The VAC was created through collaboration between the Virginia Department of Health, the American Lung Association of Virginia and the Virginia Department of Education. The members include physicians, nurses, parents, health providers, governmental agencies, respiratory therapists and others who are concerned about controlling asthma. The Coalition has spearheaded the development and passage of model legislation to provide better access to asthma medications in schools, assisted with the development of an emergency services program on asthma, the development of a low literacy asthma education module for children and their parents, and an asthma action plan for use by Virginia schools. More recently the VAC has collaborated with the Virginia Department of Health to strengthen regional coalitions and to organize statewide activities.

The child care consultants located in district health departments provide training to child care providers. One aspect of the training is medication administration training which includes a section on asthma management. The training also provides information on the asthma medication care plan that is signed by the child's doctor, the child care provider and family. In addition, web site training is available for the unregulated child care providers or providers who are not center based such as church groups, and family day homes. The web based training includes an asthma training tool kit.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	81.5	82.9	83.5	74.5	72.6
Numerator	32900	34387	35935	32078	31881
Denominator	40385	41493	43034	43078	43909
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data from the CMS 416 Report of Medicaid Eligible Recipients for Federal Fiscal Year 2009 (10/2008 - 9/2009) from DMAS.

Notes - 2008
Data from the CMS 416 Report of Medicaid Eligible Recipients for Federal Fiscal Year 2008 (10/2007 - 9/2008) from DMAS.

Notes - 2007
Data from the CMS 416 Report of Medicaid Eligible Recipients for Federal Fiscal Year 2007 (10/2006 - 9/2007) from DMAS.

An attachment is included in this section.

Narrative:
The Department of Medical Assistance Services (DMAS) has continued its emphasis on maternal and child health services. The Department's Division of Maternal and Child Health is devoted exclusively to the management of such services within the Medicaid and SCHIP populations. DMAS continues to conduct statewide provider trainings on the EPSDT program and on the necessity to conduct proper screenings. DMAS also conducts quarterly case manager meetings throughout the state. These meetings provide a valuable forum to discuss services to children. In addition, a partnership between DMAS and the VDH Lead Safe Virginia Program allowed for the matching of blood lead test results with Medicaid recipients. Alert letters are sent to every child's primary care provider that had an elevated blood lead level. These letters serve as a physician reminder to conduct all other screenings as well.

VDH Title V staff continues to participate with the Children's Health Insurance Advisory Committee. This Committee is now under private sector leadership and has formalized its purpose and objectives concerning outreach, enrollment and service improvement. This committee's goal is to improve the system's capacity to serve Virginia's children.

The Virginia Department of Medical Assistance Services (Medicaid), in partnership with VDH/Title V and the Virginia Chapter of the American Academy of Pediatrics (AAP) participated in the ABCD Screening Academy sponsored by the National Academy for State Health Policy (NASHP). As a result there is a greater use of standardized tools for developmental screening. VDH Title V has also partnered with DMAS to provide training on the use of EPSDT services. The WIC program and a number of practicies now use the Ages and Stages Questionnaire and a standardized developmental screening tool at the 9 month, 18 month, 24 month and 48 month well child visits. DMAS and VDH Title V efforts have also included the integration of Bright Futures and medical home concepts into efforts to increase EPSDT services.

The provisional Medicaid data suggests that the percent of Medicaid enrollees who are less than one year of age that received at least one periodic screen decreased in 2009 to 72.6 percent. However from 1999 there is no significant increasing or decreasing trend.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	54.6	61.4	41.4	52.2	46.8
Numerator	849	992	729	1273	931
Denominator	1554	1615	1762	2438	1988
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data from SCHIP program, DMAS.

Notes - 2008
Data from SCHIP program, DMAS.

Notes - 2007
Data from SCHIP program, DMAS.

An attachment is included in this section.

Narrative:
The Department of Medical Assistance Services (DMAS) has continued its emphasis on maternal and child health services. The Department's Division of Maternal and Child Health is devoted exclusively to the management of such services within the Medicaid and SCHIP populations. DMAS continues to conduct statewide provider trainings on the EPSDT program and on the necessity to conduct proper screenings. DMAS also conducts quarterly case manager meetings throughout the state. These meetings provide a valuable forum to discuss services to children. In addition, a partnership between DMAS and the VDH Lead Safe Virginia Program allowed for the matching of blood lead test results with Medicaid recipients. Alert letters are sent to every child's primary care provider that had an elevated blood lead level. These letters serve as a physician reminder to conduct all other screenings as well.

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The Virginia Department of Medical Assistance Services (Medicaid), in partnership with VDH/Title V and the Virginia Chapter of the American Academy of Pediatrics (AAP) participated in the ABCD Screening Academy sponsored by the National Academy for State Health Policy (NASHP). As a result there is a greater use of standardized tools for developmental screening. VDH Title V has also partnered with DMAS to provide training on the use of EPSDT services. The WIC program and a number of practicies now use the Ages and Stages Questionnaire and a standardized developmental screening tool at the 9 month, 18 month, 24 month and 48 month well child visits. DMAS and VDH Title V efforts have also included the integration of Bright Futures and medical home concepts into efforts to increase EPSDT services.

The provisional Medicaid data suggests that the percent of SCHIP enrollees who are less than one year of age that received at least one periodic screen decreased in 2009 to 46.8 percent. However from 1999 there is no significant increasing or decreasing trend.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	78.7	76.9	76.7	78.2	76.6
Numerator	81937	81647	82891	83085	
Denominator	104146	106146	108095	106239	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data not available. Entry is an estimate based on trend.

Notes - 2008
2008 data from birth certificates.

Notes - 2007
2007 data from birth certificates.

An attachment is included in this section.

Narrative:
Birth certificate data are used to calculate the adequacy of prenatal care based on the Kotlechuck Index. In 2008, 78.2% of Virginia mothers received adequate prenatal care. Although almost 80% of received adequate care, there are racial and ethnic disparities. In 2008, 82.8% of white non-Hispanic women had adequate prenatal care while 75.6% of black non-Hispanic, and 65.6% of Hispanic women had adequate care. The provisional 2009 data suggest a further decrease in

the percent of women receiving adequate care (76.6%). Overall, since 2001 there is a significant decreasing trend in the percent of women who receive adequate prenatal care.

Each year Virginia provides approximately $3.5 million of the Title V funding to the 35 health districts. In FY 2010, thirty of the thirty-five health districts used Title V funds to support prenatal care. These services range from pregnancy testing and referral to private prenatal care providers to direct prenatal care including case management within the health department. In addition, services to ensure adequate prenatal care are also provided by the Resource Mothers program, a home visiting program for pregnant teens, and the Virginia Healthy Start Initiative. Five Regional Perinatal Councils (RPCs) are funded to address issues relating to access to prenatal care, to provide perinatal outreach education and to collect and review fetal/infant mortality data at the local level.

The State Maternal Mortality Review Team reviews all deaths to women within one year of the end of their pregnancy, whether that pregnancy ended with a termination, a fetal death, or a live birth to determine the causes and circumstances in order to develop recommendations for prevention, education, training and system changes. A report covering the pregnancy-associated deaths from 1999-2001 shows that roughly one-half of the deaths are from natural causes, and the other one-half are violent deaths attributed to homicide, suicide and unintentional injuries. Title V also provides partial support for the Pregnancy Risk Assessment Monitoring System (PRAMS), a survey to obtain information regarding pregnancy experience and outcomes from a sample of new mothers. PRAMS data provides additional information on pregnancy intention, the reasons associated with inadequacy of prenatal care, and the content of prenatal care and may suggest some potential strategies to increase the number of women receiving adequate prenatal care.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	79.0	79.0	75.5	75.8	75.5
Numerator	469480	485688	482835	491656	516512
Denominator	593915	614671	639729	648674	683949
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Numerator = Number of Annual Unduplicated Recipients

Denominator = Number of Annual Unduplicated Individuals eligible for Medicaid Services, total for 0-20 yr old + an estimate of the number of uninsured children who are eligible for Medicaid but not enrolled from DMAS (120,000).

Notes - 2008
Numerator = Number of Annual Unduplicated Recipients

Denominator = Number of Annual Unduplicated Individuals eligible for Medicaid Services, total for

0-20 yr old + an estimate of the number of uninsured children who are eligible for Medicaid but not enrolled from DMAS (120,000).

Notes - 2007
Numerator = Number of Annual Unduplicated Recipients

Denominator = Number of Annual Unduplicated Individuals eligible for Medicaid Services, total for 0-20 yr old + an estimate of the number of uninsured children who are eligible for Medicaid but not enrolled from DMAS (120,000).

An attachment is included in this section.

Narrative:
Virginia's Title V and Medicaid programs have a strong history of working together on a number of issues to improve child health services and EPSDT. An interagency agreement has been in place for many years that specifically addresses mutual support for promotion and delivery of EPSDT services, data sharing regarding lead screening and follow up, and provision of services under the BabyCare program. In addition, staff works collaboratively on numerous projects and programs to improve child health and well being including the adoption of Bright Futures as a standard of child health care in the Commonwealth, conducting joint trainings, providing program updates, and to enhance enrollment in Medicaid and SCHIP. Most notably, Title V and Medicaid staff worked together to simplify the Medicaid/SCHIP enrollment process. Title V facilitated having the single application embedded in the encounter system used by local health districts so that families with eligible children can be assisted with enrollment. Since VDH and DMAS collect similar demographic information on clients the VDH informatio automatically populates the Medicaid Enrollment form. Most recently, DMAS and VDH staff worked together to implement Plan First (a family planning waiver).

Title V and Medicaid continue to work jointly to increase eligible children's enrollment in Medicaid/SCHIP.
Despite joint efforts between the Virginia Department of Health and the Medicaid agency, the percent of Medicaid eligible children who receive a service paid for by Medicaid remains fairly constant. In FY 2008, 75.8 percent of eligible children received a Medicaid paid service.

Virginia was one of eight states that received a $1 million grant for each of four years from the Robert Wood Johnson Foundation to increase enrollment and retention of children in FAMIS and FAMIS Plus (children's Medicaid). Under the direction of the national Academy for State Health Policy, experts from the national program office for Maximizing Enrollment for Kids, are working with Virginia officials to identify ways to strengthen systems, policies, and procedures. Best practices from the eight states will be shared nationally.

As of April 1, 2010, approximately 540,000 children were enrolled in the Medicaid and FAMIS programs.

Title V staff continue to serve on the Children's Health Insurance Program Advisory Committee (CHIPAC).

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	35.1	45.6	51.5	53.1	57.0
Numerator	35184	47991	55232	59303	69072
Denominator	100223	105176	107237	111771	121240

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data from Federal Fiscal Year 2009 (10/2008 - 9/2009) from DMAS.

Notes - 2008
Data from Federal Fiscal Year 2008 (10/2007 - 9/2008) from DMAS.

Notes - 2007
Data from Federal Fiscal Year 2007 (10/2006 - 9/2007) from DMAS.

An attachment is included in this section.

Narrative:
Since 2004 the percent of EPSDT eligible children aged 6 through 9 years who have received dental services during the year has significantly increased. In 2004, 32.8 percent of EPSDT eligible children aged 6 through 9 years have received dental services during the year and in 2008, 53.1 percent received dental services. In 2004 there was an ongoing lack of Medicaid dental providers which may account for the low number of children receiving a dental service. Since 2004, two changes have increased the number of Medicaid children receiving dental care. For profit dental practice franchises opened in some areas of the state. These dental practices (Kool Smiles and Small Smiles) specifically target services to Medicaid eligible children. In addition, the implementation of the Medicaid Smiles for Children program and an overall increase of 30% in Medicaid payment to dentists contributed to the significant increase in the percent of EPSDT children who receive dental services through an increasing number of Medicaid dentists. Unfortunately, as a result of Virginia's budget issues, the dental scholarship and loan repayment program funds were eliminated.

The 2009 General Assembly passed legislation that allows dental hygienist employed by the Department of Health to provide educational and preventative dental care in three of Virginia's Dental Health Professional Shortage Areas, Cumberland Plateau, Southside and Lenowisco Health Districts. The provisions of this legislation relating to the three pilot projects expire July 1, 2011. A report to the Secretary of Health and Human Resources regarding the services provided and the impact on the oral health of the citizens in the three districts will be completed by November 1, 2010.

Dr. Karen Day, director of the Virginia Department of Health's Division of Dental Health, participates on the state Dental Advisory Committee.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.8	2.9	3.3	3.4	5.2

Numerator	535	563	644	662	1026
Denominator	18832	19205	19500	19384	19788
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

An attachment is included in this section.

Narrative:
From 2001 to 2004 the percentage of SSI beneficiaries less than 16 years receiving rehabilitation services from the CSHCN program decreased as the model of care for persons with physical disabilities transitioned from the provision of direct care in clincs to intensive care coordination. Since 2004 there has been a steady increase in the percentage of SSI beneficiaries being served. Once the CSHCN program transitioned from direct care to care coordination, there is a broader range of children with varying financial circumstances and diagnoses being served. All of the CSHCN programs continue to provide outreach to potentially eligible families and coordination of services for those eligible for SSI. This is a major component of the scope of services in the contracts with the local entities managing the Care Connection for Children Centers, the Bleeding Disorders Program and the Child Development Clinics.

In FY 09, 5.2% of Virginia's SSI beneficiaries less than 16 years old received rehabilitation services from the CSHCN Program. The percent of SSI clients to total clients, less than 16 years old, is 16.5% in the Care Connection for Children Centers, 11.9% in the Bleeding Disorders Program, and 24.1% in the Child Development Clinics.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	10.5	7.6	8.3

An attachment is included in this section.

Narrative:
In 2008, 8.3% of all Virginia births were low birthweight (LBW) with births covered by Medicaid having a higher percent of low birthweight infants (9.2 % as compared to 6.6% for non-Medicaid). In general there is a significant increasing trend in the percent of LBW infants among all births and also all singleton births. Also Medicaid births compared to non-Medicaid births had a lower percent of early entry into prenatal care (74.7% vs. 88.2%) and adequate prenatal care (71.5% vs. 80.6%). The Medicaid births for black non-Hispanic, Hispanic and for white non-Hispanic all had a higher percent of low birthweight births than the non-Medicaid. However, when Medicaid, private insurance, and self-pay LBW births are compared, black non-Hispanic self-pay births had the highest percent of LBW.

The Virginia Department of Health continues to provide approximately $3.5 million of Title V funding to the district health departments. The majority of the funds support perinatal services that range from pregnancy testing and referral to prenatal care providers to direct prenatal care including case management. In addition, services to ensure adequate prenatal care are also provided by the Resource Mothers program, a home visiting program for pregnant teens, and the Virginia Healthy Start Initiative. Seven Regional Perinatal Councils (RPCs) are funded to address issues relating to access to prenatal care, and to provide perinatal outreach education and to collect and review fetal/infant mortality data at the local level.

Title V also provides partial support for the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS obtains information regarding pregnancy experience and outcomes from a sample of new mothers. Low birthweight births are over sampled in Virginia. The first two years of data are currently being analyzed regarding such factors as mothers health prior to pregnancy, pregnancy intentions, entry into prenatal care, the content of prenatal care, health behaviors during pregnancy such as smoking, and a number of other factors that will enable Virginia to look more closely at the issue of LBW and insurance status.

In the fall of 2008, the State Health Commissioner convened a work group of medical and health professionals and community and civic leaders to address infant mortality. Prematurity and LBW are major contributors to infant mortality. The Workgroup partnered various organizations to implement an educational program developed by the national Healthy Mothers, Healthy Babies Coalition. The program, text4baby, provides three free text messages each week to pregnant women and new mothers who sign up for the service by texting BABY to 511411 (or BEBE for Spanish). The messages are timed to the due date or baby's date of birth and cover such topics as birth defects prevention, immunization, nutrition, mental health, oral health and safe sleep. The messages also connect women to prenatal and infant care services and other resources.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	payment source from birth certificate	9.6	4.9	6.7

An attachment is included in this section.

Narrative:
The overall infant mortality rate decreased from 7.7 per 1,000 live births in 2007 to 6.7 in 2008. Although this is an impressive reduction, there is no statistically significant downward trend from 1999 to 2007. The number of infant deaths per 1,000 live births was higher for the Medicaid births (9.6 vs. 4.9 for non-Medicaid). Infant deaths in the Medicaid birth population for black non-Hispanic, Hispanic, and white non-Hispanic were all higher than the non-Medicaid . The black non-Hispanic Medicaid births had the highest rate of infant deaths (13.6 compared to 4.0 per 1,000 live births in white non-Hispanic/non-Medicaid births). If you compare Medicaid, private insurance and self-pay births, the black non-Hispanic self-pay group has the highest infant death rate at 25.6 per 1,000 live births. This group most likely represents the working poor who have incomes above the eligibility level for Medicaid and do not have health insurance coverage through an employer and/or cannot afford coverage. Pregnant women who are identified as self-pay also have the lowest percent of early entry into prenatal care (60.9% vs. 91.1% of women with private insurance) and the lowest percent of adequate prenatal care (52.8% vs. 83.5% of

women with private insurance).

A number of programs focus on birth outcomes and a reduction in infant deaths. The majority of the $3.5 million of Title V funding provided to the health districts supports perinatal care. Services to ensure adequate prenatal care are provided by Resource Mothers program, a home visiting program for pregnant teens, and the Virginia Healthy Start Initiative. Five Regional Perinatal Councils are funded to address issues relating to access to prenatal care, and provide perinatal outreach education. The RPCs conduct fetal/infant mortality reviews (FIMR) to identify systems issue that can be addressed at the community level to prevent infant deaths. The Child Fatality Review Team reviews child deaths including infant deaths . The Division of Injury and Violence Prevention 's child passenger safety program provides safety seats for low income families and educates parents/providers with the correct usage of child restraints. They also provide info on recalled baby equipment such as cribs and safe sleep.

In the fall of 2008, the State Health Commissioner convened a work group of medical and health professionals and community and civic leaders to address infant mortality. Prematurity andLBW are major contributors to infant mortality. The Workgroup partnered various organizations to implement an educational program developed by the national Healthy Mothers, Healthy Babies Coalition. The program, text4baby, provides three free text messages each week to pregnant women and new mothers who sign up for the service. The messages are timed to the due date or baby's date of birth and cover such topics as birth defects prevention, immunization, nutrition, mental health, oral health and safe sleep.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	74.7	88.2	84.6

An attachment is included in this section.

Narrative:
The data sources for this Health Systems Capacity Indicator are the expected payment source identified on the birth certificate and the adequacy of prenatal care as measured by the Kotelchuck Index. The overall percent of pregnant women that received prenatal care in the first trimester was 84.6% in 2008. . This is an increase from 2007 when 83.2% of pregnant women received early prenatal care. Since 1999 there is a no significant trend. As in previous years, the percent of women receiving prenatal care in the first trimester varies by race and ethnicity. In 2008, 88.8% of the white non-Hispanic women, 80.3% of black non-Hispanic women, and 72.6% of Hispanic women received prenatal care in the first trimester. The percentage also varies by payment source. For Medicaid births, 74.7% received early care while 88.2% of the non-Medicaid women received care in the first trimester. The percent of women who received first trimester prenatal care is consistently lower for the Medicaid covered women regardless of race/ethnicity (black non-Hispanic, 75.3%; Hispanic, 67.6%; white non-Hispanic, 78.2%).

If you compare Medicaid, private insurance and self-pay births, the self-pay group has the lowest

percent of pregnant women with first trimester prenatal care (60.9%) while the private insurance group has the highest percent (91.1%). The difference is consistent across all race/ethnic groups. Women who are identified as self-pay also have the lowest percent of adequate prenatal care (52.8% vs. 83.5% of women with private insurance). LBW infants and infant deaths are highest for the black non-Hispanic who is self-pay. This group most likely represents the working poor who have incomes above the eligibility level for Medicaid and do not have health insurance coverage through an employer and/or cannot afford coverage.

The Office of Family Health Services and the district health departments continue to work closely with the Medicaid agency to get women in for early prenatal care. In FY 2010, Title V funds totaling approximately $1.9 million supported thirty of the thirty-five district health departments' prenatal services.

The Virginia Healthy Start Initiative (VHSI) and the Resource Mothers program have implemented strategies to increase the number of pregnant women who enter prenatal care in the first trimester and keep their prenatal appointments. After implementing a quality improvement process to increase the number of pregnant clients who enter prenatal care in the first trimester, the data showed that 60% entered in their first trimester in 2007 and in 2008 the percent increased to 79%. The March of Dimes has been working with various organizations to promote Centering Pregnancy.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	71.5	80.6	78.2

An attachment is included in this section.

Narrative:

The data sources for this Health Systems Capacity Indicator are the expected payment source identified on the birth certificate and the adequacy of prenatal care as measured by the Kotelchuck Index. The overall percent of pregnant women that received adequate prenatal care was 78.2% in 2008. This is an increase from 2007 when 76.7% of pregnant women received adequate care. However, since 1999 there is a significant decreasing trend. As in previous years, the percent of women receiving adequate care varies by race and ethnicity. In 2008, 82.8% of the white non-Hispanic women, 75.6% of black non-Hispanic women, and 65.5% of Hispanic women received adequate prenatal care. The percentage also varies by payment source. For all Medicaid births, 71.5% received adequate care while 80.6% of the non-Medicaid women received adequate care. The percent of women who received adequate prenatal care is

consistently lower for the Medicaid covered women regardless of race/ethnicity.

If you compare Medicaid, private insurance and self-pay births, the self-pay group has the lowest percent of pregnant women with adequate prenatal care (52.8%) while the private insurance group has the highest percent (83.5%). The difference is consistent across all race/ethnic groups. Women who are identified as self-pay also have the lowest percent of early entry into prenatal care (60.9% vs. 91.1% of women with private insurance). This group most likely represents the working poor who have incomes above the eligibility level for Medicaid and do not have health insurance coverage through an employer and/or cannot afford coverage.

The Office of Family Health Services and the district health departments continue to work closely with the Medicaid agency to get women in for early prenatal care. In FY 2010, Title V funds totaling approximately $1.9 million supported thirty of the thirty-five district health departments' prenatal services.

The Virginia Healthy Start Initiative (VHSI) and the Resource Mothers program have implemented strategies to increase the number of pregnant women who enter prenatal care in the first trimester and keep their prenatal appointments. After implementing a quality improvement process to increase the number of pregnant clients who enter prenatal care in the first trimester, the data showed that 60% entered in their first trimester in 2007 and in 2008 the percent increased to 79%. The March of Dimes has been working with various organizations to promote Centering Pregnancy.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Narrative:
The percent of the federal poverty level for eligibility in Virginia's medicaid programs for infants remains unchanged at 133%.

The percent of the federal poverty level for eligibility in Virginia's SCHIP (FAMIS) program also remains unchanged at 200%.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

pregnant women.		
Medicaid Children (Age range 1 to 6) (Age range 6 to 21) (Age range to)	2009	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	 200

Narrative:
The percent of the federal poverty level for eligibility in Virginia's Medicaid programs for children less than 6 years is 133% and for children 6 to 21 years the eligibility level is 100% of the federal poverty level.

The percent of the federal poverty level for participation in the SCHIP program is 200% for children less than 19 years old and pregnant women.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	200

Narrative:
The percent of the federal poverty level for eligibility in Virginia's Medicaid program for pregnant women remains unchanged at 133%.

The percent of the federal poverty leve for eligibility in Virginia's SCHIP (FAMIS Moms) program increased to 200% effective July 1, 2009.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011
An attachment is included in this section.

Narrative:
The Virginia State Systems Development Initiative (SSDI) funds portions of the MCH Epidemiologist and the MCH Lead Analyst positions. A major focus of the grant is to develop and maintain an MCH Data Mart that facilities access to timely and accurate surveillance data which are updated as new data are released. Efforts have also focused on linking data systems in order to mine additional information for decision making. Much progress has been made in the last five years including the linking of WIC eligibility files and birth certificates and newborn screening data with birth and death certificate data. Not only do we have a Data Mart that provides easy access to the data, but we also have been funded by CDC to implement both the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Virginia Youth Survey (the Youth Risk Behavior Survey). PRAMS addressess a number of previous data gaps including intendedness of pregnancy, risk behaviors during pregnancy, and postpartum depression. We are currently in our third year of data collection. The Virginia Youth Survey was conducted in spring, 2009 and will be conducted again in 2011. A challenge for both surveys has been obtaining adequate participation.

VDH currently has access to Medicaid eligibility files for local health department clinics to determine Medicaid status. An agreement with DMAS (the Medicaid agency) allows VDH to receive Medicaid claims data and link it to birth certificate data for the purpose of evaluating a recently expanded Medicaid family planning waiver. Other data activities include testing the linking of Healthy Start data and birth certificate data.

Virginia was awarded a CDC Assessment Initative grant. The ultimate goal of the initiative is provide greater public access to data for use in community assessment and planning. The grant has provided support for the further development of the agency Data Warehouse which includes the data that is currently housed in the OFHS Data Mart.

Since the last needs assessment we have had two CSTE fellows. Both fellows now have

positions within the health department. Caroline Stampfel is the MCH Lead Analyst in the Office of Family Health Services. Andrea Alvarez accepted a surveillance position in the VDH Office of Epidemiology. A third CSTE fellow will begin work with us this summer. As in the past, we expect that the CSTE fellow will help to significantly increase our ability to make MCH data accessible to the OFHS divisions.

The Behaviroral Risk Factor Surveillance System data and the hospital discharge data is also available. Unfortunately, hospital emergency room data is not available.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	Yes

Notes - 2011

Narrative:
The ability of the MCH program's to obtain data on a number of youth risk behaviors including obesity and the use of tobacco products has improved since the last needs assessment. VDH, working closely with the Department of Education, received CDC funding for the YRBS in March 2008. Shanee Harmon was hired as the coordinator. The Virginia Youth Survey was administered in the spring of 2009. School participation was very good considering that there had been past resistance to conducting this survey. Unfortunately, Virginia fell somewhat short in meeting the required number of schools for our data to be representative of the state and included in the national survey results. However, the number of schools and students participating is adequate for our internal program planning needs. The 2009 Virginia Youth Survey data show that of the students participating in the survey 16.9% indicated that they had smoked cigarettes during the past 30 days.

The Virgina Youth Tobacco Survey also provides information on adolescents tobacco use. The most recent data is from the survey administered in the fall of 2007. Smoking rates among Virginia high school students has continued to decrease from 28.5% in 2001 to 15.5% in 2007. In 2007, 40.2% of female high school students reproted having tried cigarettes and 41.6% of male students reported that they had tried cigarettes.

The Virginia Youth Tobacco Survey is administered by the Virginia Foundation for Healthy Youth, formerly known as the Virginia Tobacco Settlement Foundation. The focus of the foundation has broadened to include both the responsibility for statewide efforts to prevent and reduce youth tobacco use and childhood obesity.

Established by the Virginia General Assembly, the Virginia Foundation for Healthy Youth was formerly known as the Virginia Tobacco Settlement Foundation. The Foundation is responsible for statewide efforts to prevent and reduce youth tobacco use and childhood obesity. The Virginia Foundation for Healthy Youth directly reaches more than 141,000 children through classroom-based prevention programs in hundreds of public schools,
after-school programs, community centers, daycares and prevention programs statewide. The Foundation's award-winning "Y do u think" marketing campaign delivers tobacco use prevention messages to 600,000 children annually through TV and radio ads and Internet content. The Foundation is funded through a portion of Virginia's share of the 1998 Master Settlement Agreement (MSA).

The Virginia tobacco Use Control Project (TUCP) within the VDH is funded though a CDC grant. The TUCP provides training, information and materials to support the implementation of policies to help Virginians choose and maintain tobacco-free lifestyles. The program works closely with coalitions, health districts and partner organizations to reduce youth tobacco use, increase cessation support and increase clean indoor air.

IV. Priorities, Performance and Program Activities

A. Background and Overview

During the development of the 2011 Title V Block Grant application, the OFHS Management Team along with a number of our external partners, reviewed the previous Title V priorities, the National and State Performance Measures, the Health Systems Capacity Indicators, the Health Status Indicators as well as needs assessment data that included the qualitative data from the key stakeholder interviews, focus groups, and the district health nurse manager survey. As a result the following eight priorities were identified and will be used to focus OFHS activities and resources during the coming year:

1. Reduce infant mortality.

2. Reduce injuries, violence and suicide.

3. Increase access to dental care and population-based prevention of dental disease across the lifespan.

4. Decrease childhood obesity.

5. Decrease childhood hunger.

6. Improve access to health care services for children and youth with special health care needs by promoting medical homes in practice.

7. Promote independence of young adults with special health care needs by strengthening transition supports and services.

8. Support optimal child development.

In addition to the 18 National Performance Measures, Virginia has identified state level performance measures that will enable the state to monitor progress related to the state MCH priorities. The State Performance Measures include the following:

1. Percent of infants born preterm (gestational age less than 37 weeks).
2. Percent of women ages 18-44 who report good/very/good/excellent health.
3. Percent of 9th -- 12th graders who have ever been bullied on school property during the past 12 months.
4. The rate of childhood injury hospitalizations per 100,000 children ages 0 -- 19.
5. The percent of low income children (ages 0 -5) with dental caries.
6. Percent of low income third grade children with dental caries.
7. Percent of women with a live birth who went to a dentist during pregnancy.
8. Percent of children eligible for WIC that are enrolled in WIC, ages 0 -5.
9. Percent of eligible children in daycares that participate in the Child and Adult Care Feeding Programs (CACFP).
10. Percent of eligible children participating in the summer feeding programs.

B. State Priorities

As part of the 2010 Five-Year Needs Assessment, Virginia developed eight statewide priorities. The following shows the relationship between Virginia's maternal and child health (MCH) priorities and specific measures that are required elements of the annual block grant report: national performance measures (NPM), national outcome measures (NOM), state performance measures

(SPM), state outcome measures (SOM), health systems capacity indicators (HSCI), and health status indicators (HSI). The priorities are not ranked. The issue of health disparities is a cross cutting issue that underlies each of the priorities.

Priority 1: Reduce infant mortality.

Reducing infant mortality is a major initiative of the Health Department. The State Health Commissioner established the Infant Mortality Workgroup which not only includes medical/health professionals, but also a wide range of community members such as local educations, civic and business officials, NAACP and the AARP. The workgroup has developed strategies and actions that can be undertaken over the next few years to improve birth outcomes and reduce infant mortality.

National Outcome Measure 01:	Infant mortality rate per 1,000 live births.
National Outcome Measure 02:	The ratio of the black infant mortality rate to the white infant mortality rate.
National Outcome Measure 03:	The neonatal mortality rate per 1,000 live births.
National Outcome Measure 04:	The postneonatal mortality rate per 1,000 live births.
National Outcome Measure 05:	The perinatal mortality rate per 1,000 live births plus fetal deaths.
Health Status Indicator 01A:	The percent of live births weighing less than 2,500 grams.
Health Status Indicator 01B:	The percent of live singleton births weighing less than 2,500 grams.
Health Status Indicator 02A:	The percent of live births weighing less than 1,500 grams.
Health Status Indicator 02B:	The percent of live singleton births weighing less than 1,500 grams.
Health Systems Capacity Indicator 04:	The percent of women with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
National Performance Measure 08:	The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
National Performance Measure 11:	The percent of mothers who breastfeed their infants at 6 months of age.
National Performance Measure 18:	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
State Performance Measure 01:	Percent of infants born preterm (gestational age less than 37 weeks).
State performance Measure 02:	Percent of women ages 18-44 who report good/very good/excellent health.

Priority 2: Reduce injuries, violence, and suicide among Title V populations.

Unintentional injuries remain a leading cause of death for persons aged 1 to 64. The majority of these deaths are preventable. In 2008, 2,769 Virginians died as a result of unintentional injuries. Of these 454 were under the age of 24 years old. Suicide took the life of 205 individuals aged 10 -- 24 and 146 individuals aged 0 -- 24 died as a result of homicide. There is also a need for

continued efforts to promote healthy behaviors to reduce morbidity and mortality. Concerns relating to injury, violence and suicide, were identified in the needs assessment. The key stakeholders identified the need for expanded prevention and education services for children relating to health issues, and the need for increased education for the prevention of risky behaviors among adolescents. Activities to address this priority include continuing population-based prevention education and provider training on the identification of violence and appropriate documentation and referral.

Health Status Indicator 03A;	The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.
Health Status Indicator 03B:	The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.
Health Status Indicator 03C:	The death rate per 100,000 from unintentional injuries due to motor vehicle among youth aged 15 through 24 years.
Health Status Indicator 04A:	The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.
Health Status Indicator 04B:	The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.
Health Status Indicator 04C:	The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.
National Performance Measure 10:	The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes 100,000 children.
National Performance Measure 16:	The rate (per 100,000) of suicide deaths among youths aged 15 through 19 .
State Performance Measure 03:	Percent of 9th -- 12th graders who have ever been bullied on school property during the past 12 months.
State Performance Measure 04:	The rate of childhood injury hospitalizations per 100,000 children ages 0-19.

Priority 3: Increase access to dental care and population-based prevention of dental disease across the lifespan.

The key stakeholders indicated that there is a growing number of persons who are experiencing limited access to medical and dental care. In 2000, the first Surgeon General's report on oral health identified a "silent epidemic" of dental and oral diseases that burdens some population groups. Oral diseases can place a major burden on low-income and underserved individuals in terms of pain, poor self-esteem, cost of treatment, and lost productivity from missed work or school days. Dental disease and access to dental care is a chronic problem among low-income populations in Virginia. In the public hearings, the need to increase access to dental services for women and children was identified. The lack of access to dental care was also a finding from the key stakeholder interviews and was identified as a significant need by the district health nurse managers. The Division of Dental Health's approach to this includes infrastructure building services such as oral health surveillance and recruitment of public health dentists. The Division also maintains a quality assurance program for public health dentists. Population-based services include dental education, community water fluoridation, and the fluoride mouth rinse and varnish program. A number of local health departments provide clinical dental services.

National Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

State Performance Measure 05: The percent of low income children (ages 0-5) with dental caries.

State Performance Measure 06: Percent of low income third grade children with dental caries.

State Performance Measure 07: Percent of women with a live birth who went to a dentist during pregnancy.

Health Systems Capacity Measure 07B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Priority 4: Decrease childhood obesity.

According to recent data, Virginia has the 27th highest rate of overweight youths ages 10-17. Recent data collected by the Virginia Foundation for Healthy Youth through a youth-reported telephone survey indicates that the highest childhood obesity rates are found in Southwest Virginia, with 28%, closely followed by Southeast Virginia, with 24%. Over the past decade, overweight/obesity has significantly increased in children living within the Commonwealth of Virginia. According to the National Survey of Children's Health in 2003, almost one-fourth (24 percent) of Virginia's children are overweight and 15 percent are at risk for being overweight. The 2007 survey found that approximately 31% of Virginia children age 10 -- 17 were overweight or obese. Lack of regular physical activity, accessibility to calorie dense foods, larger portion sizes, family lifestyles and lack of interest in health and media messages contribute to the childhood overweight dilemma. In addition, many children live in areas that are not conducive to safe physical activity. This approach to the overweight issue includes population-based services such as public awareness and education and coordinating school and community based physical activity programs as well as an infrastructure level approach to monitor obesity data and policy development.

National Performance Measure 11: The percent of mothers who breastfeed their infants at 6 months of age.

National Performance Measure 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Priority 5: Decrease childhood hunger.

State Performance Measure 08: Percent of children eligible for WIC that are enrolled in WIC, ages 0 to 5.

State Performance Measure 09: Percent of eligible children in daycares that participate in Child and Adult Care Feeding Programs (CACFP).

State Performance Measure 10: Percent of eligible children participating in summer feeding programs.

Priority 6: Improve access to health care services for children and youth with special health care needs by promoting medical home in practice.

Having a medical home has been identified as an important way to ensure that children and especially CSHCN receive the comprehensive care that they need. In the medical home concept a physician provides primary care that is easily accessible, family centered, coordinated, and culturally appropriate. In 2005/2006, approximately 44 percent of Virginia CSHCN received coordinated, ongoing, comprehensive care within a medical home. The key stakeholders and the OFHS management team identified the need for increased access to care and the need for coordinated and culturally-appropriate care. Some activities related to this priority include collaborating with other community agencies and state level groups to expand the availability of medical homes (infrastructure building services) and working with families to ensure that children are referred to a medical home (enabling services).

National Performance Measure 01:	The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.
National Performance Measure 03:	The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

Priority 7: Promote independence of young adults with special health care needs by strengthening transition supports and services.

National Performance Measure 06:	The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.
Health Systems Capacity Indicator 08:	The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.

Priority 8: Support optimal child development.

National Performance Measure 12:	Percentage of newborns who have been screened for hearing before hospital discharge.
Health Systems Capacity Indicator 02:	The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.
Health Systems Capacity Indicator 03:	The percent State children's Health Insurance Program enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100
Numerator	113	146	145	174	
Denominator	113	146	145	174	
Data Source				Newborn Screening Program	Trend Analysis
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
2009 data not yet available.
Entry is an estimate based on performance in previous years.

Notes - 2008
2008 data from Virginia Newborn Screening Program.
Numerator = number receiving appropriate follow-up (linked to appropriate specialist)
Denominator = number of confirmed cases

Evidence = info from PCP or specialist, oral or written.

Notes - 2007
2007 data from Virginia Newborn Screening Program.
Numerator = number receiving appropriate follow-up (linked to appropriate specialist)
Denominator = number of confirmed cases

Evidence = info from PCP or specialist, oral or written.

a. Last Year's Accomplishments
During FY 2009, the Virginia Newborn Screening Program (VNSP) continued to screen all newborns born in the state for the twenty-eight disorders recommended by the American College of Medical Genetics. VNSP nurses followed up on over 13,350 abnormal and unsatisfactory results and assured that confirmed cases were appropriately referred for treatment (see Form 6 for data).

The VNSP report "Protecting Newborns for 40 Years, 1966-2006" has been added to the VDH web site along with disease-specific parent fact sheets in both English and Spanish, as well as other VNSP education resources.

Support continued for the metabolic treatment centers at Eastern Virginia Medical School and at the Departments of Medical Genetics of University of Virginia and Virginia Commonwealth University. Under contractual agreements, these centers provide: (1) consultation for providers to facilitate early diagnosis and treatment of infants with abnormal screening results; (2) laboratory services to monitor blood levels and make recommendations for modification of diet and metabolic formula; (3) patient and family education; (4) coordination of genetic testing for the family to assist in making informed decisions; and (5) provision of data and long-term case management information to the Director of Genetics and Newborn Screening (GNS).

The Newborn Screening Program Manager continued to serve on the New York Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC) Advisory Committee and on Work Group 4. This work group presents multiple opportunities for the VGP to be involved in identifying regional barriers regarding standardization of newborn screening testing and treatment and the identification of possible strategies for solutions. The Division Director for Child and Adolescent Health continued to serve on the NYMAC Medical Home Work Group.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain screening of twenty-eight inborn errors of body chemistry--metabolic, endocrine, and hematologic.			X	
2. Monitor all abnormal newborn screening results and conduct follow up per protocol including aggressive follow-up on all critical results.			X	
3. Provide metabolic formulas and modified low protein food products to patients diagnosed through VNSS who are <300% of the federal poverty level.		X		
4. Maintain the Virginia Infant Screening and Infant Tracking System (VISITS) birth defects database and ensure that all newborn screening diagnosed cases are included in VISITS.				X
5. Maintain contracts with medical specialists statewide to provide metabolic treatment and consultation.	X			
6. Refer all newborn screening diagnosed cases to Care Connection for Children, the CSHCN program for care coordination.		X		
7. Continue newborn screening related educational activities to healthcare providers and consumers.				X
8. Distribute the newborn screening Parent Brochure to obstetric offices and to hospital based prenatal classes.		X		
9. Review and make recommendations regarding proposed legislation or policies addressing newborn screening issues.				X
10.				

b. Current Activities

Data indicate that VNSP continues to fulfill the mission of identifying newborns with heritable disorders and assuring follow-up. VNSP continues the following activities: (1) screening all infants for 28 inborn errors of body chemistry; (2) tracking and following up all abnormal results; and (3) maintaining contracts for three metabolic treatment centers. VNSP refers diagnosed cases to Care Connection for Children (CCC), which is part of the Children with Special Health Care Needs Program. CCC care coordinators assist families in obtaining medically necessary metabolic formulas, required dietary supplements, and community-based services as needed.

Data from the Division of Consolidated Laboratory Services (DCLS) are being matched with Vital

Records birth certificate data to improve quality of contact and demographic information and follow up services.

An internal workgroup has been formed to identify opportunities for integration of various follow-up activities between the blood spot and hearing screening programs. This workgroup meets regularly to define current workflows and seek efficiencies in follow up processes.

c. Plan for the Coming Year

In FY 2011, VNSP will continue the following: (1) ensure screening of all infants for this panel of inborn errors of body chemistry; (2) track and follow up on all abnormal results and assure that confirmed cases are referred into treatment in a timely manner; and (3) provide necessary education and technical assistance to providers. Newborn screening staff will refer newly diagnosed children to the CCC network for care coordination. An automatic electronic referral system between newborn screening and CCC will be implemented in FY 11. This will be an enhancement of the Virginia Vital Events Screening and Tracking System (VVESTS), which went live in late FY 2010.

VNSP will continue contracts with the three metabolic treatment centers in the state for the medical management of children diagnosed with metabolic diseases via newborn screening. Continued collaboration and participation in the regional NYMAC collaborative is planned for the previously involved staff.

Activities to formalize the integration of staff functions for follow-up of blood spot and hearing screening will continue.

Existing educational materials for parents and providers will continue to be disseminated through the web and other mechanisms.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**104990**					
Reporting Year:	**2008**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	104985	100.0	130	7	7	100.0
Congenital Hypothyroidism (Classical)	104985	100.0	2185	43	43	100.0

Galactosemia (Classical)	104985	100.0	393	5	5	100.0
Sickle Cell Disease	104985	100.0	79	42	42	100.0
Biotinidase Deficiency	104985	100.0	247	9	9	100.0
Cystic Fibrosis	104985	100.0	651	14	14	100.0
Homocystinuria	104985	100.0	189	0	0	
Maple Syrup Urine Disease	104985	100.0	49	1	1	100.0
beta-ketothiolase deficiency	104985	100.0	0	0	0	
Tyrosinemia Type I	104985	100.0	31	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	104985	100.0	34	2	2	100.0
Argininosuccinic Acidemia	104985	100.0	8	0	0	
Citrullinemia	104985	100.0	8	1	1	100.0
Isovaleric Acidemia	104985	100.0	44	2	2	100.0
Propionic Acidemia	104985	100.0	163	1	1	100.0
Carnitine Uptake Defect	104985	100.0	533	5	5	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	104985	100.0	19	0	0	
Methylmalonic acidemia (Cbl A,B)	104985	100.0	163	0	0	
Multiple Carboxylase Deficiency	104985	100.0	163	0	0	
Trifunctional Protein Deficiency	104985	100.0	6	0	0	
Glutaric Acidemia Type I	104985	100.0	14	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	104985	100.0	1896	6	6	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	104985	100.0	163	4	4	100.0
Long-Chain L-3-Hydroxy Acyl-	104985	100.0	6	0	0	

CoA Dehydrogenase Deficiency						
3-Hydroxy 3-Methyl Glutaric Aciduria	104985	100.0	19	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	104985	100.0	163	1	1	100.0
S-Beta Thalassemia	104985	100.0	6	4	4	100.0
Sickle C Disease (Hb SC)	104985	100.0	42	25	25	100.0
Sickle E Disease (Hb SE)	104985	100.0	3	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	60	65	65
Annual Indicator	58.3	58.3	59.8	59.8	59.8
Numerator					
Denominator					
Data Source				National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	70	70	70	70

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

In FY 2009, each clinic in the Child Development Clinic network (CDC) surveyed parents to determine their level of satisfaction with care received. Response rates for the nine CDCs ranged from 9 to 98 percent with a network average of 43.6%. Findings show an overall satisfaction rate of 97%, with a range from 83% to 100%. These percentages have been similar over the years.

A Care Connection for Children (CCC) Family Survey is conducted every two years. The last one was conducted in 2008 and yielded a strong response rate of 45%, which is higher than the 2006 survey response rate of 33%. The response rate for the Spanish survey recipients continued to be higher with 52% in 2008. Statewide, a very high rate of overall satisfaction (96%) was found. In addition, families served by the CCCs gave high marks to the quality of their interaction with staff. Survey findings were remarkably similar to the findings in the 2006 survey relative to areas where families need the most assistance. Statewide recommendations include the following: improve delivery of transition services, partner more with the dental health resources, and better assess parents' need for support and connecting to resources. The next survey will be conducted in the fall 2010.

The 2009 Virginia Bleeding Disorders Program (VBDP) formal family and client satisfaction survey found 85% very or somewhat satisfied with the care coordination services received from the Hemophilia Treatment Centers. The major issue identified was the need for adequate insurance coverage for the uninsured and underinsured.

Family representatives continued to serve on the Virginia Early Hearing Detection and Intervention Program Advisory Board, the Hemophilia (Bleeding Disorders) Advisory Board, and the Virginia Genetics Advisory Committee.

The staff from the Virginia Center for Family Involvement and Support and the Virginia Family to Family Health Information and Education (Va F2F) Center continued to facilitate meetings of the CCC parent coordinators. The meetings promote networking, sharing, and training.

CSHCN staff continued to partner with many parent organizations including Family Voices, Parent to Parent, and the federally funded Va F2F Center. These family organizations and local and state partners collaborate and educate on behalf of children and young adults with special needs and their families and assist them in obtaining timely access to information, resources, supports, and services. Five CCC centers continued to employ parents of CSHCN as parent coordinators and two of them maintained family resource libraries. The sixth CCC center has a family advisory group in conjunction with the hospital's advisory group.

VBDP continued to host routine meetings of consumer advisory boards for three of the four Hemophilia Treatment Centers. It also hosts parent networking events. One CDC has an advisory group with participation of parents, a local pediatrician, school personnel, mental health workers, and social services workers. Each CCC continued to have advisory committees with participation of parents and CYSHCN to increase family and community involvement in addressing issues relevant to the needs of the special needs population.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include family members and youth with special needs as				X

members of committees and advisory boards of the CSHCN program.				
2. Provide family-to-family support as a basic service of Care Connection for Children (CCC) centers.			X	
3. Work with Family to Family Health Information and Education Center and other family organizations to enhance the ability of families to partner in decision-making.				X
4. Administer parent satisfaction surveys at CCC centers, Child Development Clinics (CDC), and the Virginia Bleeding Disorders Program (VBDP).				X
5. Monitor activities and outcomes; adjust CSHCN state plan for meeting HP 2010 goals as needed.				X
6. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
7.				
8.				
9.				
10.				

b. Current Activities
Staff from the Virginia Center for Family Involvement and Support and the Va F2F Center continues to meet with the CCC parent coordinators. The group completed a strategic plan for increasing family involvement. The CCC parent coordinators are focusing on face-to-face parent support and implementing an Individualized Parent Education and Empowerment Plan as a tool for working with parents of CCC clients.

A State Implementation Grant for Integrated Community Systems for CSHCN was funded in June 2009. Several strategies of the project, Virginia Systems Improvement Project (VSIP), are enhancing the role of families as partners. Two part-time community liaison workers are providing information/referral services and family-centered trainings in the African-American and Hispanic communities. In addition, each position will be recruiting at least two cultural brokers in their respective minority communities.

Six focus groups of African-American and Hispanic families of special needs children will be conducted to learn more about their experiences with the health care system. To date, all materials have been developed for this initiative, to include the focus group questions, protocol, and recruitment materials. All materials have also been translated into Spanish. VCU is currently recruiting participants and the groups will be conducted in April or May.

c. Plan for the Coming Year
VSIP activities will be implemented to increase understanding and awareness of racial and ethnic disparities in services provided to CSHCN. Through an arrangement with VA-LEND (Leadership Education in Neurodevelopmental Disabilities), additional analyses of Virginia's National Survey of CSHCN dataset will be completed to look at what predictor variables are significantly associated with each of the six outcomes and how they are associated. A report of the results will be developed in the form of an article to be submitted for peer review.

Strengthening family partnerships will continue to be a high priority for the CSHCN Program. The Va F2F Center at the Virginia Partnership for People with Disabilities has a crucial role in VSIP. Information gained from the focus groups of minority parents of CYSHCN will be analyzed and recommendations developed to enhance their experiences with the health care system. Va F2F Center will assist with identifying parents to participate in the Learning Collaborative as both team members and faculty and to participate in other educational sessions. Va F2F will continue to

employ community liaison workers to enhance outreach to parents of minority populations and train cultural brokers to help sustain this outreach effort beyond the term of the project.

The Virginia Home Visiting Consortium was organized in 2006 as a group of public-funded home visiting programs with goals to review the current system of home visiting programs and to make recommendations for strengthening the infrastructure and service delivery. The group has sought to build better linkages between local communities' existing home visiting programs so that the diverse needs of families can be more appropriately addressed. The Consortium will have a crucial role in VSIP to improve care coordination and communication in the medical home with a focus on family-centered care.

Families will continue to serve on advisory boards of the CSHCN Program. All six CCCs will have parents of CSHCN as members of CCC teams and continue to enhance their family-to-family support services. CDCs, CCC centers, and VBDP will survey families to determine their satisfaction with the services and make necessary changes to best meet identified needs. VBDP will continue to host routine meetings of consumer advisory boards of the Hemophilia Treatment Centers.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	60	60	60
Annual Indicator	54.5	54.5	43.9	43.9	43.9
Numerator					
Denominator					
Data Source				National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	65

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
In FY 2009, 99.4% of the clients in the Child Development Clinic (CDC) network and 100 percent of both the Care Connection for Children (CCC) network and the Virginia Bleeding Disorder Program (VBDP) had a primary care provider.

All children seen for CDC, CCC, and VBDP services were screened to determine if they had a primary care provider. Families without a primary care provider received encouragement to establish a medical home and were informed of choices to obtain one. CDCs have a performance goal to improve communication with the medical home by sending the clinic's final report to the medical home within fourteen days of the completion of the CDC evaluation. Results on this performance target ranged from 52 to 100 percent of reports mailed to the primary physician within fourteen days (when permission was given to release the report to physician), with a CDC network average of 80%. This marks significant improvement from the 50% network average in 2006 but is a slight decrease from the 82% in 2007.

Collaborations continued with local public and private pediatric mental health service providers. Access to mental health services in Virginia is limited for multiple reasons including shortages of pediatric mental health resources, low insurance reimbursement, and families having to pay prior to services being rendered.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with other community agencies to expand the availability of medical homes for CSHCN.				X
2. CCCs, CDCs, and the Bleeding Disorders Program work with families to ensure that children served are referred to a medical home and to a dentist.			X	
3. Partner with state AAP, Medical Home Plus, Division of Dental Health and other organizations to provide training and technical assistance to primary care practices on the medical home concept.				X
4. Monitor activities and outcomes; adjust CSHCN state plan as needed.				X
5. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Virginia Community Healthcare Association (VCHA), comprised of Community Health Centers, Migrant Health Centers, and Rural Health Centers, is a partner in Virginia Systems Improvement Project. It is managing the Learning Collaborative (LC), including the recruitment of member primary care practices, organization of learning sessions, arranging for expert faculty,

and use of quality improvement tools to assist practices with process improvement. Another partner, VA Chapter of AAP, is assisting in recruiting non-VCHA practices to the LC, serve as faculty and coaches, and assisting with statewide spread of lessons learned. A timeline for the Learning Collaborative project has been developed. Practices are now being recruited, the curriculum is being finalized and data collection/reporting requirements and mechanisms will be designed. Initial site visits to participating practices (pre-training visits) will occur in July-August, 2010 with the official "kick off" Learning Session to be held in September/October 2010.

CCC and VBDP staff is working with the Division of Dental Health in the implementation of the State MCH Oral Health Service Systems Grant, which is designed to improve access to dental care for young children and CSHCN. Staff continue to assist families in finding a medical home for their CYSHCN.

c. Plan for the Coming Year

Assisting families with locating a medical home and providing technical assistance and training for health professionals about the medical home concept will continue to be a high priority for the CSHCN Program. Strategies of the Virginia Systems Improvement Project include implementation of learning collaborative on developmental screening in the medical home with an emphasis on the use of standardized screening tools, early identification, care coordination, and family-centered care. Another strategy will be working with Virginia's Home Visiting Consortium to enhance the skills of home visitors through training and technical assistance efforts and to better define the role of home visitors as care coordinators in support of primary care practices.

Staff will follow the current work of the National Academy for State Health Policy on medical home and partner with the Department of Medical Assistance Services to explore ways that Medicaid/SCHIP policy may be used to promote medical homes. DMAS is a crucial partner in the Virginia Systems Improvement Project. Strategies include conducting a web-based training for primary care providers and their office staff on general EPSDT screening requirements and billing procedures. DMAS also will redesign the Medicaid case management service for young CSHCN and initiate any needed regulatory and Medicaid State Plan changes.

CCC centers, CDCs, and VBDP will continue to monitor the status and refer 100 percent of their clients without a medical home to resources.

Staff will continue to participate in the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services to promote medical homes and a system of care for CSHCN identified through newborn screening. There are initiatives targeted to providers and parents, and staff will take advantage of this collaboration's outputs.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	70	70	70	75	75
Annual Indicator	65.6	65.6	63.7	63.7	63.7
Numerator					
Denominator					
Data Source				National	National

				CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75	75	75	75	75

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The Care Connection for Children centers (CCC), Child Development Clinics (CDCs), and Virginia Bleeding Disorder Program (VBDP) prepared their annual plans based on the HP 2010 outcomes for CSHCN. All three are contractually required to refer all eligible children without insurance to either Medicaid or FAMIS (SCHIP) and to refer potentially eligible SSI recipients to SSI. They are also required to follow-up with families to determine the outcome of the applications.

A major component of the CCC program and the VBDP is the provision of insurance case management to assist families to obtain, understand, and use health insurance. Extra emphasis is provided to clients transitioning from pediatric to adult health care to ensure continuous insurance coverage as the client ages out of public insurance and their parent's private insurance. VBDP clients receive medical insurance case management through a contract with Patient Services Incorporated (PSI), a non-profit organization with a mission to help people who live with certain chronic illnesses or conditions locate suitable health insurance coverage to enable them to access optimal medical treatment. PSI also provides assistance to VBDP clients with the cost of health insurance premiums.

In FY 2009, 98.5% of CDC network, 92.2% of CCC network, and 91.0% of VBDP clients had health insurance coverage. In all three programs, 19.4 percent of clients under age 16 years also were receiving SSI. This has steadily increased over the years and is almost double the 10.2% rate in FY 2006.

In FY 2009, 464 clients (CCC: 448 and VBDP: 16) received financial assistance from the CSHCN Pool of Funds (POF). This Pool provides money to assist uninsured and underinsured clients. Covered services include durable medical equipment, medications, diagnostic testing, therapies, hospitalizations, and dental orthodontic and prosthodontic appliances (for those with maxillofacial conditions). The POF was evaluated to identify areas of underinsurance and services not

covered. Medications and durable medical equipment continue to be the most requested POF services.

The 2009 Family Satisfaction Survey conducted by VBDP noted that 56% of those with health insurance found costs to usually or always be reasonable. Ninety percent reported that they were able to see the health care provider of their choice.

The CSHCN Program continued work with DMAS to remove obstacles causing underinsurance of CSHCN on Medicaid and FAMIS. DMAS provided updated manuals and training for CCC centers, VBDP, and CDCs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Refer 100% of eligible children in the CCCs, CDCs, and the Bleeding Disorders Program to Medicaid, FAMIS, and SSI.		X		
2. Provide health insurance case management as a basic service of the CCC centers and the Bleeding Disorders Program.		X		
3. Monitor activities and outcomes; adjust the CSHCN state plan as needed.				X
4. Work with other agencies to identify issues and remove obstacles that cause underinsurance.				X
5. Provide financial assistance from the CSHCN Pool of Funds for the uninsured and underinsured clients of CCC and VBDP.		X		
6. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
7.				
8.				
9.				
10.				

b. Current Activities

Of the families in Virginia who completed the National Survey of CSHCN in 2005/2006, 63.7% indicated that they have adequate private and/or public insurance to pay for services their children need. This is lower than the state's 2007 objective of 70%, as well as a decrease from the 65.6% result in the 2001 survey; however, it is higher than the 2005/2006 national average of 62%.

CDCs, CCCs, and VBDP continue to refer all potentially eligible children to Medicaid, FAMIS, and SSI programs and follow-up with families to assure that the application is processed. The majority (94.2%) of clients continue to have health insurance coverage. The number with no insurance decreased from 7.6% in FY 2004 to 6% in FY 2005 and FY 2006, and then increased to 6.2 % in FY 2007 and 6.3% in FY 2008. In FY 2009, the percentage has decreased to 5.8%. Many within this group are not eligible for public insurance and cannot afford private insurance.

Clients continue to receive financial assistance from the CSHCN POF with the number served increasing from 324 in FY 2006 to 464 in FY 2009. The clients are those who are not eligible for public insurance, who cannot afford private insurance, or whose insurance does not cover the needed service. POF guidelines have been modified in an effort to address areas of underinsurance. Staff continues to work with DMAS to identify issues and remove obstacles that cause underinsurance of CSHCN receiving Medicaid and FAMIS.

c. Plan for the Coming Year
CDCs, CCC centers, and VBDP will continue to refer all potentially eligible children to Medicaid, FAMIS, and SSI programs and follow-up with families to assure that their applications are processed. They will continue to provide annual plans based on the HP 2010 outcomes for CSHCN.

Clients will continue to receive assistance from the CSHCN Pool of Funds as long as feasible. Due to many years of level funding for CCC and VBDP, the continuation of the Pool of Funds is in jeopardy. The increase in the cost to provide infrastructure and enabling services has decreased the amount of funds that can be allocated to the Pool of Funds (payment for direct services). The decrease in state funding is also a factor. The guidelines for the use of POF have steadily become more stringent, and the utilization of the funds will continue to be closely monitored.

Work with DMAS will continue to identify issues and remove obstacles that cause underinsurance of CSHCN receiving Medicaid and FAMIS. Updated manuals and training by DMAS will be provided for CCC centers, VBDP, and CDCs.

Staff will provide data and information on insurance status and gaps in coverage to child health advocates and coalitions working to increase insurance coverage for children in Virginia.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83	85	85	90	94
Annual Indicator	80.1	80.1	89.6	89.6	89.6
Numerator					
Denominator					
Data Source				National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	94	94	94	94	94

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
The CSHCN Program maintained its network of six Centers of Excellence called Care Connection for Children (CCC). The centers provided information and referral to resources, care coordination, family-to-family support, assistance to families with the transition from child to adult oriented health care systems, and training and consultation with community providers on CSHCN issues.

The network of nine Child Development Clinics (CDCs) provided multidisciplinary diagnostic evaluations of children suspected of having developmental and/or behavioral disorders. CDCs offered trainings and technical assistance to providers in the community and served as training sites for psychology students.

Using the four levels of the MCH pyramid as a conceptual framework, a Stakeholders Group of persons with a strong interest in developmental services examined the capacity and gaps of the current service delivery system in Virginia, which includes the Child Development Clinics. The input has been used to develop a white paper with recommendations for the best use of Title V funds for these services.

The Virginia Bleeding Disorders Program (VBDP) supported a statewide network of comprehensive care centers for clients of all ages with inherited bleeding disorders and their families. It implemented training for clients, families, and health care professionals on several topics including home infusion and coagulation update. Collaboration continued with the Virginia Chapter of the National Hemophilia Foundation to facilitate training and networking events for clients.

In FY 2009, the CCC network provided care coordination and pool of funds services to 3,668 clients. An additional 2,120 children and their families benefited from CCCs information and referral services. The VBDP served 275 clients (158 persons ages 0-21 and 117 persons 21 years and older). The CDC network served a total of 3,417 clients. Multidisciplinary, comprehensive diagnostic evaluations with follow-up medical conferences and care coordination were provided for 2,147 new clients. An additional 336 clients were assessed for eligibility for Virginia's Medicaid Developmental Disability Waiver. Another 934 clients received other services, including developmental screens, medical treatment, and family consultations.

During FY 2009, CCC staff began providing care coordination services for newly diagnosed infants with sickle cell disease identified through newborn screening. Joint training sessions of staff from CCC and Sickle Cell Treatment centers has enhanced their collaboration to ensure follow-up of the infants. Staff maintain close working relationships with local early intervention programs. One of the CCC centers is housed with the local early intervention program, which enhances referrals and collaboration in the delivery of services. Another useful resource is the Hearing Aid Loan Bank funded by Virginia Early Hearing Detection and Intervention Program (VEHDIP).

All of the networks in the CSHCN Program continued to evaluate their services and make changes as needed. Staff worked with families and community agencies to continue to

strengthen the system of care for CSHCN. The Division Director represents the agency on Part C's (Early Intervention) interagency advisory council and stakeholder groups that are overseeing the system transformation.

High priority was given to assisting CSHCN and their families to deal with emergencies. Examples include assisting families to develop an emergency care plan and assemble a Disaster Supplies Kit. Staff was also involved in planning for emergency shelters for special needs populations.

From May 2009 through May 2010, a Virginia EHDI team is participating in National Initiative for Children's Healthcare Quality learning collaborative entitled "Improving the System of Care for CYSHCN". The Virginia project is focused on decreasing the percentage of newborns who failed their initial hearing screen who are lost to follow-up. The team consists of two parents of hearing impaired children, an audiologist, a speech and language specialist, two pediatricians, a hospital social worker in the audiology department, a nurse manager in a hospital hearing screening program, the CSHCN director, and VEHDI program staff. All were involved in quality improvement projects.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide leadership in planning, developing, and implementing efforts to improve services to CSHCN.				X
2. Provide care coordination for CSHCN from birth through twenty years of age in CCC and persons of all ages in VBDP.		X		
3. Provide a system of services for people with bleeding disorders through the Bleeding Disorders Program.	X			
4. Provide diagnostic and evaluation services for children from birth through twenty years of age through the Child Development Clinics.	X			
5. Partner with others to coordinate care for children with developmental and behavioral programs through the Child Development Clinic network.		X		
6. Monitor activities and outcomes; adjust the CSHCN state plan as needed.				X
7. Participate in statewide committees and interagency councils for CSHCN issues.				X
8. Provide training and technical assistance.				X
9. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
10.				

b. Current Activities

Virginia's needs assessment has been updated to reflect the current status relative to the six core outcomes of a system of care for CYSHCN. VDH convened a summit of partners representing a wide range of stakeholders including parents. It was organized so that six groups met to review draft issue briefs and make suggestions for changes-- one brief for each core outcome. The finalized briefs will be used to provide guidance to a statewide consortium which will be formed to carry forward with system-building initiatives. A planning team of the stakeholders is developing the infrastructure for a consortium to be convened in September 2010.

VDH convened another Stakeholders Group of persons with a strong interest in developmental

services. Their input was used in the development of a white paper that provides recommendations for the best use of Title V funds for these services. It has been presented to the Health Commissioner for approval. Recommendations include strengthening early identification of at-risk children, focusing on the young child, enhanced collaboration with the Early Intervention (EI) Program, and filling service gaps for young children.

A team continues with the NICHQ collaborative on newborn hearing screening. Staff from the state's EI Program joined the team and has been instrumental in the team's partnership with a local EI agency to implement tests of change. The team has begun to spread the successful changes to other locations.

c. Plan for the Coming Year

The Virginia Systems Improvement Project will continue to be implemented. In addition to the strategies described earlier, data on racial and ethnic disparities will be examined and a plan developed to address disparities in services provided to CYSHCN. Infrastructure for statewide policy and planning will also be strengthened through the establishment of a Consortium for CYSHCN.

Once the recommendations in the white paper "Developmental Services for CSHCN" are approved by the Health Commissioner, a strategic plan will be developed and implemented.

CDCs will continue to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children with the greatest need are served. Clinics continue to provide annual plans based on the HP 2010 outcomes for CSHCN.

The CCC centers will continue in their mission to develop family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families. Changes in the CCC database completed during 2010 will be implemented to allow electronic referrals from newborn screening (bloodspot) programs to CCC. The system will also inform the screening programs of the outcomes of the referrals. Mechanisms will be explored to electronically capture the number of persons served by CCC's family to family services.

VBDP will continue collaboration with the Virginia Hemophilia Board, Hemophilia Treatment Centers and Virginia Chapter of the National Hemophilia Foundation to facilitate training and networking events for clients.

National case management certification will continue to be a goal for CCC staff. During FY 09, seventeen CCC staff received and/or maintained their national case management certification (45% of the staff). During FY 10 the number increased to nineteen staff making the total 50%. The number is steadily increasing toward the goal of 60%.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	6	7	8	45	45
Annual Indicator	5.8	5.8	37.8	37.8	37.8

Numerator					
Denominator					
Data Source				National CSHCN Survey	National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	55	55	55	55

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
Virginia's plan to meet HP 2010 outcomes for CSHCN includes numerous activities to facilitate the development of a transition system for CSHCN that will assure that youth with SHCN participate as decision-makers and as partners; have access to health insurance coverage; and have a medical home that is responsive to their needs. Specific activities have been included in the contractual arrangements with local managers of the clinics and centers in all Care Connection for Children (CCC), Child Development Clinics (CDCs), and Virginia Bleeding Disorder Program (VBDP) networks. These include identification of all open cases of children age 14 years and above to prioritize the group targeted to receive transition services for health care, education, social, and employment needs. CCC and the VBDP are identifying "adolescent friendly" specialists to assist with transitions. Having educational consultants located in CCCs, CDCs, and hemophilia clinics has greatly enhanced communications with the local schools regarding youth clients' transition services.

CDCs focused on serving younger children to identify developmental, behavioral, and emotional problems as early as possible. Clients and families were assisted with the many transitions that

occur such as from early intervention to special education and from preschool to kindergarten. When appropriate, adolescents were invited to participate in the interpretive interview of their evaluation findings and recommendations, either with their parents or by having their own separate individual interpretive interview. Recommendations related to transition to adult life were included. Clients were referred to their local school systems and/or rehabilitative services.

The CCC care coordinators continued to update their Transition Tool Kit. The kit includes specific worksheets organized by aspects of transition to be used during encounters with the client and family. These worksheets help to identify the client's strengths and challenges during the transition process. They also serve as a measure of progress toward transition over time. The minimum goal is to provide at least five transition encounters between the client, family, and care coordinator. Divided into five age groups between ages 14 and 21 years, the worksheets provide a mechanism to prompt and track progress towards that goal. The kit also includes a sample emergency information form for families to complete and provide to caregivers, emergency rooms, day care providers, and other relevant persons who may be part of the youths' care network.

The Sickle Cell Program has developed and distributed a transition manual to assist those clients; fully engaging use of this manual will be a focus for the year ahead.

Hemophilia Treatment Centers (HTCs) implemented the Hemophilia Advisory Board's approved strategies that include identifying core competencies for adequate patient transition to be monitored via pre/post test, developing a portable, accessible medical record (which is password protected) to be given to the patient and family, and ensuring the availability of affordable, comprehensive, continuous health insurance. VBDP hosted regular conference calls among the HTC staff to enhance the implementation of these strategies. VCU and UVA HTC's continued to conduct Transition Clinics to assist youth in their transition from youth to adulthood.

CCC staff partnered with the Departments of Education and Rehabilitative Services to implement the state's 2009 Transition Forum.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide transition of services from pediatric to adult health care services in the CCCs, CDCs, and the Bleeding Disorders Program.		X		
2. Monitor activities and outcomes; adjust the CSHCN state plan as needed.				X
3. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Of the families in Virginia who completed the National Survey of CSHCN in 2005/2006, 37.8% indicated that their older children have received the services necessary to make appropriate

transitions to adult health care, work, and independence. This is lower than the 2005/2006 national average of 41.2%.

CDCs, CCCs, and VBDP continue to assist youth in the transition to adult care. Staff is also providing training and support for pediatric and adult health care providers to promote the development of youth as partners in health care decision-making. CCC staff partnered with the Departments of Education and Rehabilitative Services to implement the state's 2010 Transition Forum.

Staff participate with the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC). Two other regional consortia and the NYMAC are piloting transition initiatives. Virginia will take advantage of any opportunities that may come from this effort.

c. Plan for the Coming Year

CDCs, CCC centers, and VBDP will continue to assist older children in the transition to adult care. The Transition Tool Kit will continue to be updated and shared with community partners. CCC staff will partner with the Departments of Education and Rehabilitative Services to implement the state's 2011 Transition Forum.

The CCC Inter-center Work Group has determined that transition is an area of significant need for focus in the coming year. A focused plan will likely be a key issue for the newly-developed CYSHCN Consortium.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	87	87.5	87.5
Annual Indicator	85.8	81.5	79.6	73.2	74.6
Numerator					
Denominator					
Data Source				National Immunization Program	Trend estimate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88	88	88	88	88

Notes - 2009

2009 data not yet available. Entry is an estimate based on trend.

Notes - 2008
National Immunization Program Data Calendar Year 2008 from CDC website.

Notes - 2007
National Immunization Program Data Calendar Year 2007 from CDC website.

a. Last Year's Accomplishments
Immunization data indicate that coverage rates are trending down. In 2008, the rate for 4:3:1:3:3 dropped to 73.2%. This appears to be related to several issues: an increase in medical and religious exemptions; adverse publicity regarding concerns about vaccines and autism; and the recession.

The Division of Immunization administers the Vaccines for Children program through which many children are eligible to receive immunizations at no or low cost.

In FY 2009, Title V supported activities to help increase immunization rates focused on the provision of child care health consulting activities, including assessment. The Title V Early Childhood Projects director, along with the contracted state child care health consultant, supervised Healthy Child Care Virginia (HCCV) training and technical support activities for public health nurses and other professionals serving as child care health consultants. Key consulting activities are to provide CASA immunization audits and help child care centers institute system changes to support all attendees reaching and maintaining up-to-date immunizations. The director provided consultation to the Virginia Department of Social Services (DSS) to work with child care providers in developing their knowledge and ability to assure complete immunizations among child care attendees. A part-time contracted coordinator provided ongoing consultation and technical assistance to the field. Eight health districts used Title V funds to support activities related to increasing immunization rates through assessment, early childhood asthma management, and child care health consultant activities.

Title V supported several state and local efforts to provide parents and caregivers with information about immunizations. Remaining Governor's New Parent Kits were distributed throughout the state. The kit contained the Bright Futures Health Record and a customized Baby's First Year calendar highlighting immunizations needed for each month and the toll-free VDH Division of Immunization information line. Materials have been posted online for access.

The Commonwealth established a Virginia text4baby implementation team in summer 2009 that included key stakeholders and members of the VDH Commissioner's Infant Mortality Workgroup. An educational program of the National Healthy Mothers, Healthy Babies Coalition (HMHB), text4baby delivers timely health tips via a new free mobile phone information service providing timely health information to pregnant women and new mothers during pregnancy and through a baby's first year using text messaging.

Title V funds support case management activities that help increase immunizations. Resource Mothers, a lay-person support program available in 87 communities, continued to assist teen parents in getting their infants properly immunized. Roanoke health district used some of their Title V allocation to support their CHIP case management program for low-income children ages 0-5.

The Virginia Immunization Information System (VIIS), the state immunization registry, continues to be developed through the Division of Immunization, Office of Epidemiology. Other activities included provision of immunizations through all local health departments; development and implementation of local immunization action plans; collaboration with public and private sector partners such as WIC and Medicaid HMOs; and surveillance, CASA assessment and evaluation activities led by the VDH Division of Immunizations, Office of Epidemiology.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide funding to local health districts to deliver child care health consultation services to help increase immunization rates.				X
2. Promote Bright Futures Guidelines to increase utilization of preventative health care.				X
3. Support home visiting programs such as CHIP and Resource Mothers.		X		
4. Participate in Project Immunize Virginia Coalition.				X
5. Collaborate with stakeholders to publish information regarding immunization requirements including distribution of New Parent Kits.		X		
6. Review and make recommendations regarding proposed legislation or policies addressing access to health care, particularly immunizations.				X
7. Provide support to the Virginia Immunization Registry as needed.				X
8.				
9.				
10.				

b. Current Activities

Title V staff continue to work with the Division of Immunization to promote vaccination in keeping with the recommended schedule. Title V supported activities that continue to have a major emphasis on working with child care providers to improve immunization rates and other health indicators. The Early Childhood Projects director and contracted coordinator sustained the number of child care health consultants to about 300 statewide. In FY 2010, nine local health districts are using Title V funds to support child care health and safety. Districts review CASA results to determine how they can work with local child care providers to improve rates within their areas. Education, training, and outreach activities are being conducted for child care and Head Start staff to monitor immunization records.

Title V continues to partner with DSS in reaching child care providers. A quarterly Healthy Child Care electronic newsletter reaches over 10,000 child care professionals throughout the state. It is archived on the VDH web site. Topics focus on timely issues such as the importance of immunizations and keeping medical records up-to-date, health insurance, pandemic flu and disease prevention, mental-health and social-emotional competence, and working with CSHCN.

Virginia continues to collaborate with the Healthy Mothers, Healthy Babies Coalition to promote text4baby throughout the state with a $300,000 grant provided by CareFirst BlueCross BlueShield.

c. Plan for the Coming Year

The contracted child care health consultant will continue providing technical assistance to field staff through the end of the State Early Childhood Comprehensive Systems grant funding. To build sustainability, child care health consulting has been incorporated as a working committee

under the VDH Nursing Council. Consultation and partnering with Project Immunize Virginia, the VDH Division of Immunization, Head Start Collaborative, and the DSS Divisions of Child Care Programs and Licensing will continue to assist with infrastructure building and quality enhancement activities. The Child Care Health and Safety Newsletter will continue to be published electronically quarterly.

DCAH will partner as appropriate with the statewide immunization registry as they expand their system, which currently contains over seven years of immunization histories available to health care providers and schools. In addition to recording immunizations, the system also provides up-to-date recommendations for immunization scheduling, generates recall notices, develops immunization reports, identifies areas of under-immunized populations and maintains an inventory and ordering module for providers. This is administered through the Office of Epidemiology, Division of Immunization.

VDH maintains the Bright Futures web site (www.healthyfuturesva.com) launched in July 2009. This site uses short videos to personify anticipatory guidance themes and the periodicity visit schedule. The site covers key themes on child development, oral health, healthy weight/nutrition, and medical visits through age four including immunizations. Use of the web site has grown steadily, averaging around 20,000 hits/month. In FY 2010, the remainder of the site will be completed to address remaining visits and themes. Immunizations for early and middle childhood as well as adolescents will be addressed. The Bright Futures web site will be maintained and updated. The marketing and promotion plan will be updated as the site is rolled out to encourage use by additional populations and stakeholders.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	19	17	16	15.8	15.6
Annual Indicator	16.3	16.9	16.7	15.5	14.1
Numerator	2521	2617	2605	2369	2167
Denominator	154419	154735	155692	153155	153155
Data Source				VA birth data & NCHS pop estimates	VA prov birth data & NCHS pop estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15.4	15.2	15.2	15	15

Notes - 2009
2009 provisional birth data used for number of births to teens. Denominator entry is an estimate based on previous year.

Notes - 2008
Number of teen births from Vital Records 2008 data. Denominator from NCHS 2008 population estimates.

Notes - 2007
Number of teen births from Vital Records 2007 data. Denominator from NCHS 2007 population estimates.

a. Last Year's Accomplishments
Although the overall teen birth rate is flattening out, analyses suggest that rates are increasing among older (18-19 year old) Hispanic teenagers. The Teen Pregnancy Prevention Initiative (TPPI) operated by VDH was funded by TANF through an appropriation from the Virginia Department of Social Services (VDSS). In FY 2009, funds for the Better Beginnings Coalitions were eliminated. Vacant positions that supported the teen pregnancy prevention initiative were also eliminated, though funding for the program was maintained. Programs continued to operate in the seven identified health districts. Central office support for statewide activities (e.g., data analysis and dissemination of fact sheets; dissemination of new information in the literature; promotion of National Campaign to Prevent Teen Pregnancy initiatives, etc) was not maintained at prior years' levels due to funding cuts. Family Planning clinics continued to serve minors as needed. The Resource Mothers and Girls Empowered to Make Success programs continued with mentoring efforts to prevent primary and secondary pregnancies.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate and oversee administration of teenage pregnancy prevention programming in seven health districts: Alexandria, Crater, Eastern Shore, Norfolk, Portsmouth, Richmond City and Roanoke City.				X
2. Evaluate teenage pregnancy prevention programs.				X
3. Continue effort to integrate HIV, STD, and teen pregnancy prevention messages.				X
4. Develop the statewide adolescent sexual health plan.				X
5. Develop the skills and capacity of youth service providers to serve the target population through information networks.				X
6. Review and make recommendations regarding proposed legislation or policies addressing teens and their access to health care and other health related services.				X
7.				
8.				
9.				
10.				

b. Current Activities
Programs continue to operate in the seven identified health districts. Central office support for statewide activities was restored with the hiring of a part-time TPPI coordinator in August 2009, funded by MCH. Statewide budget reductions in September 2009 however, caused funding to be reduced. Programs had to recalculate appropriated monies and work plans to reflect the new funding levels. Central office activities including dissemination of new information in the literature; promotion of National Campaign to Prevent Teen Pregnancy initiatives; and data support with analysis as well as distribution and implementation of an in-house evaluation survey has been reinstated. There has been an increase in communication between the central office and TPPI

sites. Responding to TANF funding requirements has improved now that dedicated staff is again in place. Preliminary analyses still suggest that rates may be increasing among older (18-19 year old) Hispanic teenagers.

Analyses of teen birth rates are being conducted to assist localities that may apply for federal teenage pregnancy prevention funding opportunities. The Girls Empowered to Make Success Program was eliminated in budget cuts.

c. Plan for the Coming Year

TPPI funding has been reduced by half, making it is imperative for the sites to operate at maximum potential for return on investments. The central office has level-funded each site, shifted the program in one locality from a contractor to the local health district, and provided specific options to the sites for implementing evidence-based or evidence-informed programs with a common evaluation. Sites may also leverage funds with existing adolescent reproductive health clinic services. Staff will continue to monitor program implementation, provide technical assistance to sites, share information on current literature, and support analysis of evaluation data. Staff are also preparing to respond to the anticipated federal funding announcement about the Personal Responsibility Education Program.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	39	39	39	40	41
Annual Indicator	44.0	25.1	29.6	45.3	49.4
Numerator	897	50	180	391	
Denominator	2038	199	608	863	
Data Source				Crater Health District Survey	Statewide Dental Assessment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	55	55	55	55

Notes - 2009

Data source is Virginia Statewide 3rd Grade Public School Dental Assessment, 2009.

Notes - 2008

Data are derived from dental surveys of school-age children in Virginia.
2008 data are from a survey of Crater Health District. This number may be higher than previous estimates because of a Medicaid provider in that area. These data are unweighted. Data for

2009 will be from a statewide needs assessment of school-age children in Virginia. This comprehensive study will examine the oral health condition and needs of over 2,000 third-grade children from throughout the state.

Numerator is the unweighted number of children who received a sealant. Denominator is the unweighted number of third grade children examined. Data collection on third graders in targeted counties will continue through 2008.

Notes - 2007
Data are derived from dental surveys of school-age children in Virginia. 2007 data are from the 2007 Piedmont Health District Basic Screening Survey of third-grade children. Piedmont is a rural health district and may not be entirely representative of all third graders, but this is the most recent data available. Data presented are unweighted.

Numerator is the unweighted number of children who received a sealant. Denominator is the unweighted number of third grade children examined. Data collection on third graders in targeted counties will continue through 2008.

a. Last Year's Accomplishments
The Division of Dental Health (DDH) supported local health department dental programs through providing a dentist to coordinate a quality assurance program, assisting with recruitments for local health department dental programs, and orienting new dental staff. Training was provided for 100 dental staff in 25 health districts regarding pediatric dentistry and other public health dental topics. In FY 2009, on-site quality assurance clinic reviews were provided for dental programs in Henrico, Danville, Central Shenandoah, Central Virginia, Prince William and Loudoun Health Districts. In FY 2009, VDH dental clinics provided 39,500 visits for individuals in more than 149,000 clinical services with a value of nearly $13 million dollars. Almost 70% of visits were for children of school age (5-18 years old) and more than 12,000 dental sealants were placed. Central Shenandoah, Cumberland Plateau, Norfolk, Peninsula, Piedmont, Roanoke, Thomas Jefferson, Western Tidewater and Central Virginia used Title V funds to help support their dental programs and provide comprehensive dental care (treatment and prevention, including dental sealants).

A pilot dental sealant program was conducted in three health districts (Crater, Henrico and Piedmont) in FY 2009 for children enrolled in schools with high enrollments in the free lunch program. More than 1,200 sealants were provided for 547 children who participated in the program.

The topical fluoride rinse program with 47,236 children participating in 226 schools in 58 counties in rural areas without access to community water fluoridation. Eight schools were added during the school year. In addition to rinse supplies, training was provided to children, teachers, and nurses. The rinse coordinator completed monitoring site visits to one-third of the schools.

More than six million citizens of all ages consumed water that has been optimally fluoridated. DDH monitored 145 systems for compliance in conjunction with the VDH Office of Drinking Water (ODW). DDH worked with ODW to provide a course on fluoridation for water treatment plant operators. The course was offered in collaboration with the Virginia Rural Water Association and the Salem Water Treatment Plant. A spokesperson training course was conducted for public health and private dentists in collaboration with the Virginia Dental Association and American Dental Association. Several funding sources assist localities through grants with initiations or upgrades of water systems.

A statewide survey of 7,838 third grade children was completed in the 2008-2009 school year that included a sample of 201 schools across the state. VDH used the Basic Screening Survey Tool and assistance from the Association of State and Territorial Dental Directors to complete the sampling and data collection. DDH staff were the examiners for the survey. The survey results

are being reported in FY 2010.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nine health districts utilize MCH funding to provide sealants.	X			
2. A quality assurance program provides on site review of all health department dental programs that placed more than 12,000 sealants in FY 2009.	X			
3. Maintain a data entry program to record the number of oral health services provided.				X
4. Recruitment and orientation of new dentists; provide on-site review of programs.				X
5. Develop and distribute educational materials regarding dental sealants.	X		X	
6. Train local public health dental staff on pediatric dentistry to provide a competent oral health workforce.		X		
7. Review and make recommendations regarding proposed legislation or policies addressing children's access to dental care.				X
8. Provide education regarding dental sealants and other oral health topics to more than 10,000 school age children.			X	
9. Collect and analyze data on 3rd grade children regarding disease status and dental sealants.			X	
10. Pilot a school based dental sealant program.	X			

b. Current Activities

In FY 2010, DDH received a state budget reduction that eliminated two full time positions (epidemiologist and adult oral health educator) as well as the school fluoride rinse and school oral health education programs.

At the same time, DDH was awarded a "Grants to Support Oral Health Workforce Activities" from HRSA. The grant activities are primarily for dental hygienists in three local health districts (Cumberland Plateau, Lenowisco and Southside) to work under a new practice protocol that will provide dental sealant programs in schools and referrals for care.

The ongoing DDH pilot for a dental sealant program in three health districts (Crater, Piedmont and Henrico), funded through PHHS and general funds, provided 327 children with 648 dental sealants to date.

DDH assisted in recruitments, orientations, and technical assistance for local programs as well as providing quality assurance visits to programs in Alexandria and Arlington this year.

With PHHS funding, DDH hired a wage epidemiologist who is analyzing and reporting on the statewide needs assessment of third grade children. Overall, the survey shows that 47.4% of children had decay experience and 13.5% of children need early or urgent care. There are racial and ethnic as well as socioeconomic and regional disparities within the state with regard to all indicators, including dental sealants. Statewide, 47% of children had at least one permanent molar sealed. Overall this is an increasing trend over previous year.

c. Plan for the Coming Year

PHHS funding also allowed DDH to collect the final phase of data on 1,500 children in three counties for the school fluoride rinse program evaluation. This three-year evaluation will determine the effectiveness of the program in rural areas and provide additional data on the oral health status of children. It is anticipated that the data analysis and report will be completed in early FY 2010.

A new grant from the Williamsburg Foundation provided the Three Rivers Health District an opportunity to purchase and staff a mobile dental van and funding from Bon Secour has allowed Richmond City Health District to expand its mobile program. DDH anticipates ongoing technical assistance and guidance for these new and existing programs. DDH dental program oversight will continue as dentists retire from the VDH systems with site visits, recruitment, orientation, and training.

The Community Water Fluoridation Program will continue to provide grant funding for communities to start or upgrade fluoridation equipment to maintain optimal fluoridation. Future goals are to continue to provide grant funding to communities to start or maintain optimal community water fluoridation. This has become increasingly important in the difficult economic times particularly for small rural systems and the length of time many communities have had existing equipment.

DDH plans to expand the school based dental sealant program to other targeted areas.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.1	2.1	1.9	1.9	1.9
Annual Indicator	2.7	1.9	2.4	1.5	1.9
Numerator	41	28	36	22	
Denominator	1508838	1490293	1508669	1510607	
Data Source				VA Death data & NCHS pop estimates	Trend estimate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1.8	1.8	1.8	1.8	1.7

Notes - 2009
Data for 2009 not yet available. Entry is an estimate based on trend.

Notes - 2008

Data from 2008 Death Certificate File.
Denominator from NCHS population estimates.

Notes - 2007
Data from 2007 Death Certificate File.
Relevant changes in Virginia Law:
July 1, 2002:
--All children under age six must be properly restrained in a child safety seat or booster seat. Violations will result in a $50 fine.
--All children between their 6th and 16th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.
July 1, 2007:
--Child restraint devices are required for children through the age of seven (until 8th birthday). Violations will result in a $50 fine.
--Rear-facing child restraint devices must be placed in the back seat of a vehicle. In the event the vehicle does not have a back seat, the child restraint device may be placed in the front passenger seat only if the vehicle is either not equipped with a passenger side airbag or the passenger side airbag has been deactivated.Violations will result in a $50 fine.
--Children can no longer ride unrestrained in the rear cargo area of vehicles. Violations will result in a $50 fine.
--All children between their 8th and 16th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.

a. Last Year's Accomplishments
Title V funded staff in the Division of Injury and Violence Prevention (DIVP) continued to provide managerial oversight to a child passenger safety program that provides public and professional education to increase correct child restraint usage for children 0-8.

DIVP annually provides about 16,700 child restraints and child passenger safety education to indigent families through 145 Low Income Safety Seat Distribution and Education Program sites across the Commonwealth (primarily local health departments).

DIVP staff participated and/or conducted 49 community child safety seat events for the general public, at which the installation of 622 safety seats were inspected and errors were corrected. DIVP supports 81 permanent community safety seat check stations that are widely distributed across the Commonwealth. Since 2006, the public has brought in over 10,000 safety seats to be checked by the community safety seat check stations. These sites are required to record findings and corrections made to each safety seat on the VDH Child Safety Seat Checklist Form. Analysis of the forms submitted by the stations indicates that the misuse rate of child safety seats and booster seats is on the decline. The misuse rate determined from those forms submitted for analysis in 2009 was 67%. This was a decrease from 74% in 2008, and 80% in 2007. This information is a preliminary indicator of the success of broader statewide educational efforts to promote the proper installation of child safety seats.

DIVP promoted National Child Passenger Safety Week during September 2009 with a statewide mailing of postcards promoting CPS fact sheets and materials on the DIVP web site to licensed and non-licensed daycares, family physicians, local health departments, OB/GYN practices, pediatricians, sheriffs, VA police chiefs, and injury prevention advocates. As a result, providers downloaded a packet of fact sheets 2,363 times from the web site.

DIVP staff responded to 467 phone calls to the DIVP information line from the public with questions about child passenger safety.

A pilot project was implemented that integrated safe sleep messages into child passenger safety education of parents of infants. Four thousand five hundred packets of safe sleep materials including wearable blankets were distributed to parents of infants when they received child

passenger safety information at 45 Low Income Safety Seat Distribution and Education Program sites, Community Safety Seat Check Stations or local health departments that chose to participate in the program.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate statewide child restraint distribution and education program.				X
2. Disseminate child restraint devices.		X	X	
3. Provide public and provider education materials.		X		
4. Review and make recommendations regarding proposed legislation or policies addressing motor vehicle safety issues for children.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DIVP staff are continuing to coordinate the low income safety seat distribution and education program and the child safety seat check station program. Plans are underway for the observance of Child Passenger Safety Week in September 2010. The demand from communities to establish new safety seat check stations continues to be supported. DIVP staff also continues to support community based child safety seat check events across the state. DIVP staff is revising the child passenger safety website and has developed interactive maps to identify child passenger safety services and contact information for community resources.

DIVP is developing a variety of child passenger safety resources for health care providers based on the needs identified by a survey of pediatricians and maternity hospitals. DIVP is implementing a First Ride Safe Ride project with maternity hospitals throughout the state to encourage the safe transportation of newborns from hospitals through the adoption of policies, the provision of resources, and training opportunities for hospital staff. Information collected from twelve focus groups that DIVP is contracting throughout Virginia will provide insight into child passenger safety behaviors and beliefs among hard to reach parents and caregivers. This information will be used to better direct the outreach and education efforts of DIVP to high risk audiences.

c. Plan for the Coming Year

DIVP staff will continue to disseminate child restraint devices, coordinate state and local child restraint outreach and education activities, and collaborate with state community and highway safety partners to implement a variety of strategies to prevent injuries associated with motor vehicles, particularly injuries experience by children under the age of eight (8). Staff will continue to monitor state and federal legislation that impacts child safety. DIVP will expand its efforts to address child passenger safety with high risk audiences.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		40	43	49	50
Annual Indicator	39	39	49.8	42.7	48.3
Numerator					
Denominator					
Data Source				National Immunization Program	National Immunization Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	51	52	53	53	53

Notes - 2009
2009 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2006.

Notes - 2008
2008 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2005.

Notes - 2007
2007 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2004.

a. Last Year's Accomplishments
The Division of Nutrition, Physical Activity, and Food Programs (DNPAFP) worked with the University of Virginia (UVA) to develop a web-based training course in lactation management. The web address for the course is www.breastfeedingtraining.org. During FY 2009, DNPAFP worked with UVA to develop three additional modules to add the already existing curricula. The three new modules focus on breastfeeding the preterm and late-preterm infant. These new modules were launched in November 2008. Participation and evaluations are continuing to be tracked through the web site. Revisions to the site's content will be made if necessary. During FY 2009, there were 3,466 healthcare professionals who registered for the course. UVA continued to send monthly reports to DNPAFP with necessary feedback.

VDH's Statewide Breastfeeding Advisory Committee is continuing to make efforts to gain wider representation from other areas such as workplace, insurance companies, and day care centers. The Breastfeeding Advisory Committee distributed its final Strategic Plan 2009-2014 to all of its members in December 2008. The Strategic Plan contains four goals and numerous objectives for each goal. The Strategic Plan and other documents that have been developed through the Breastfeeding Advisory Committee are available on the VDH website.

DNPAFP used the funding awarded from the United States Department of Agriculture (USDA) to continue to develop and promote the Breastfeeding Peer Counselor Program in Virginia. All breastfeeding peer counselors around the state were trained on USDA's VENA (Value Enhanced Nutrition Assessment) Initiative, which will be a shift in counseling style for WIC personnel.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the Breastfeeding advisory committee.				X
2. Continue the Breastfeeding Peer Counselor Program.		X		
3. Promote Breastfeeding during Breastfeeding Awareness Month.			X	
4. Continue to distribute breastfeeding educational materials to WIC clients.			X	
5. Review and make recommendations regarding proposed legislation or policies addressing breastfeeding.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DNPAFP is continuing to work with the University of Virginia (UVA) to host the web-based training course in lactation management available at www.breastfeedingtraining.org. Currently, DNPAFP is working with UVA to develop five additional modules related to breastfeeding-friendly hospital policy to add the already existing curricula that meet Maintenance Of Certification Part II and Part IV requirements and provide learners with access to comprehensive and user-friendly approaches to support for breastfeeding. Participation and evaluations are continuing to be tracked through the web site. Revisions to the site's content will be made if necessary. Currently, there have been 1,392 healthcare professionals who have completed the course for FY 2010. UVA will continue to send monthly reports to DWCNS with necessary feedback.

VDH's Statewide Breastfeeding Advisory Committee, which now has 20 members, continues to hold quarterly meetings in Richmond. The Breastfeeding Advisory Committee will work toward the four goals outlined in the Strategic Plan 2009-2014. The Breastfeeding Advisory Committee continues to work with VDH's CHAMPION Obesity Prevention Plan with the promotion and support of breastfeeding-friendly programs and grants.

DNPAFP recently converted the entire Breastfeeding Peer Counselors contract to VDH wage employees. There are currently 81 breastfeeding peer counselors throughout Virginia who continue to work within the Virginia WIC Program.

c. Plan for the Coming Year

DNPAFP is actively managing the Breastfeeding Peer Counselor Program throughout each of the 35 health districts in the Commonwealth. Currently, DWCNS has 81 breastfeeding peer counselors hired. District WIC offices are using the Loving Support Breastfeeding Curriculum to train peer counselors. DNPAFP will be working with James Madison University's Institute for Innovation in Health and Human Services to develop a web-based training program incorporating the Loving Support Curriculum as its basis. DNPAFP also continues to seek training opportunities as well as develop continuing education for peer counselors in order to keep them

abreast of the latest research in the field of lactation management.

DNPAFP will continue to work with the University of Virginia (UVA) to host and offer continuing education units through the web-based training course on lactation management. Five additional modules that meet Maintenance Of Certification Part II and Part IV requirements and provide learners with access to comprehensive and user-friendly approach to support for breastfeeding will be added and launched in FY 2011.

VDH's Statewide Breastfeeding Advisory Committee will continue to hold quarterly meetings and seek wider representation. The Breastfeeding Advisory Committee will work toward the four goals outlined in the Strategic Plan 2009-2014. .

A press release for Breastfeeding Awareness Month (August 2010) is being developed and will be available to local agencies.

Breastfeeding peer counselors continue to work within the Virginia WIC Program promoting and supporting breastfeeding within each locality.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	96.8	96.2	97.8	96.9	95.4
Numerator	99359	101886	104863	101757	96661
Denominator	102647	105890	107261	104990	101295
Data Source				Virginia EHDI program & VA Birth data	Virginia EHDI program & VA provisional birth data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Data from the Virginia Early Hearing Detection and Intervention System, 2008 and the number of provisional occurrent births from Virginia Health Statistics, 2008.

Notes - 2008
Data from the Virginia Early Hearing Detection and Intervention System, 2008 and the number of provisional occurrent births from Virginia Health Statistics, 2008.

Notes - 2007
Data from the Virginia Early Hearing Detection and Intervention System, 2007 and the number of occurrent births from Virginia Health Statistics, 2007.

a. Last Year's Accomplishments
During FY 2009, the Virginia Early Hearing Detection and Intervention (VEHDI) Program continued to administer the state's newborn hearing screening program as required by the Code of Virginia. VEHDI conducted numerous activities related to data systems improvement, technical assistance to hospitals, policy development, and improving follow up.

In FY 2009, the Virginia Infant Screening and Infant Tracking System (VISITS) II requirements document, application development and testing, and data conversion preparation were completed in collaboration with VDH Office of Information Management (OIM). Plans to integrate VISITS II into the new state web-based integrated system Virginia Vital Events and Screening Tracking System (VVESTS) including the Electronic Birth Certificate (EBC) continued.

VEHDI worked to assure that hospitals continued to screen all newborns for hearing loss prior to discharge and report required data through VISITS. VEHDI submitted quarterly reports to hospitals on their screening rates as well as annual status reports to hospital CEOs. Hospital staff continued to be trained in reporting requirements and program protocols.

VEHDI networked with bordering state programs and providers to facilitate reporting of resident infants born in neighboring states. Proposed regulations were developed for the program to be consistent with the 2007 Joint Commission on Infant Hearing Statement. The program also collaborated with the Centers for Disease Control and Prevention (CDC) for VEHDI Program Evaluation. New follow-up processes to improve EHDI 1-3-6 objectives were developed. VEHDI applied for and received funding from the HRSA Universal Newborn Hearing Screening and Intervention grant to support an improved 1-3-6 follow up plan. This funding will help reduce the number of infants who are missed, provide additional part-time temporary staff support, increase the number of infants screened who are born outside of hospitals, and promote the VEHDI Program statewide.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enhance, implement, and evaluate the Virginia Early Hearing Detection and Intervention Program.				X
2. Maintain and improve the Virginia Infant Screening and Infant Tracking System database.				X
3. Provide training for hospital staff.				X
4. Provide hospitals with quarterly updates on program strengths and areas of need.				X
5. Provide annual report to hospitals' CEOs.				X
6. Monitor newborn hearing screenings results and ensure retesting as needed.				X
7. Monitor hearing screenings for out of hospital births.				X
8. Collaborate with other states to track resident infants born in border states.				X
9. Review and make recommendations regarding proposed legislation or policies addressing newborn hearing screening and access to services.				X
10.				

b. Current Activities
In FY 2010, the VEHDI Program continues to operate numerous activities related to screening, follow up, family- to-family support, and information systems and policy improvements.

Hospitals continue the aim to screen all newborns for hearing loss prior to discharge and to report required data through VISITS. VEHDIP continues to provide technical support and training to hospital staff. Screening performance measure data have been disseminated in quarterly status reports to hospital programs as well as through annual reports to hospital CEOs. Hospitals not meeting data reporting requirements received targeted interventions. NICHQ Learning Collaborative activities through PDSA methods are being conducted in selected partnering hospitals to improve overall screening practice and procedures.

VISITS II was released as part of VVESTS in April 2010. Eight statewide trainings were held for hospital users. The integration of VISITS with VVESTS provides users with existing birth certificate data as the base of the EHDI reporting record.

Proposed regulations continue to move through the regulatory process. VEHDIP protocols are also being revised. Training needs of birthing centers and certified professional midwives are being assessed.

A parent roadmap is being developed to explain screening processes. Funding for the Virginia Hearing Aid Loan Bank was provided and one year funding was secured for the "Guide By Your Side", family-to-family support program.

c. Plan for the Coming Year
In FY 2011, the VEHDI Program will continue with routine operations. Hospitals will receive both quarterly status and annual reports providing feedback on screening, referral, and other data reporting performance measures. Hospital staff will continue to be trained in data reporting requirements using VISITS II. Six site visits as part of a quality improvement initiative will be conducted.

Enhancements for the VISITS II system will be developed and implemented. A post-implementation survey among hospital users will be conducted and suggestions for improvement will be incorporated where feasible. VEHDIP staff in collaboration with VDH OIM will develop and test system enhancements. Tracking and surveillance of program-targeted conditions (i.e. children with hearing loss, birth defects, at-risk for developmental delay) will be conducted using VISITS II data. Role-based web access and/or reporting will be assessed for audiologists and primary care providers. The feasibility of providing primary care providers with hearing screening results online through the VDH Virginia Immunization Information System will be evaluated.

The revised 1-3-6 Follow Up Plan will be evaluated with a continued focus on children lost to follow up and lost to documentation. Integrated follow up between the newborn blood spot and hearing screening programs will be implemented where efficient and feasible.

A public awareness campaign will be conducted in targeted markets. This will include airing Loss and Found, a PSA featuring real families whose infants were found to have hearing loss through newborn hearing screening. Loss and Found will be distributed to hospitals and other partners.

Proposed regulations will continue moving through the state regulatory process. Plans are to have the regulations finalized prior to the end of FY 2011.

Collaborative efforts with stakeholders will continue and be further developed. VEHDI will disseminate timely and comprehensive data to healthcare professionals, policymakers, and other

stakeholders. The program plans to assess the feasibility of engaging OB/GYN doctors in the EHDI process. Two 30-minute online modules for primary care providers will be developed and pilot tested. A data exchange and matching agreement will be developed with Virginia Department of Behavioral Health and Developmental Services (DBHDS) to facilitate both child find activities as well as complete follow up and evaluation data for both VEHDI and the state Part C program. Four VEHDI staff will continue to be supported by Title V funding.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	5	5	4.9	4.9
Annual Indicator	7.3	7.3	7.3	7.2	7.2
Numerator					
Denominator					
Data Source				National Survey of Children's Health	National Survey of Children's Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4.8	4.8	4.8	4.7	4.7

Notes - 2009
State survey data not available.
Data from the National Survey of Children's Health, Released 2009.

Notes - 2008
State survey data not available.
Data from the National Survey of Children's Health, Released 2009.

Notes - 2007
State survey data not available.
Data from the National Survey of Children's Health, Released 2005.

a. Last Year's Accomplishments
VDH continued to collaborate with state and local partners to help reduce the percent of children without health insurance. VDH programs continued integrating outreach, education, and application assistance where feasible. VDH participated in the state mandated Children's Health Insurance Advisory Committee.

The WebVISION-FAMIS-PlanFirst application link continued to be used by local health departments since statewide implementation began September 2005. In FY 2009, the link identified 3,735 potential eligibles and 517 were subsequently identified as enrolled in a FAMIS

program.

In FY 2009, five health districts used Title V funds to support clinic-based and case management efforts to identify, refer, and assist with enrollment or re-enrollment processes for publicly funded children's health insurance programs.

Information regarding publicly supported children's health insurance programs (FAMIS programs for Medicaid and SCHIP) is distributed through Division of Child and Adolescent Health programs and posted on the Bright Futures website (www.healthyfuturesva.com).

Healthy Child Care Virginia (HCCV) electronically reposted the 2009 newsletter for child care provider professionals with information devoted to children's health insurance programs and the importance of a medical home.

VECCS continued with implementation of the Smart Beginnings state strategic plan. In FY 2009, VECCS sponsored an integrated planning session for all early childhood stakeholders to update Virginia's Plan for Smart Beginnings. The Governor's initiative has five focused early childhood systems integration areas: early care and education, family support and parent education, health, mental and oral health, public policy, and public awareness. The health component focuses on the medical/dental home and health insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with partners to increase enrollment in state sponsored health insurance programs.				X
2. Participate in initiatives and coalitions aimed to reduce uninsured rates.				X
3. Fund local health districts for outreach and enrollment activities.		X		
4. Support surveillance, monitoring, and dissemination of data related to children's health and insurance status.				
5. Maintain and improve data system enhancement to generate public insurance application for potential eligibles served in local health districts.				X
6. Review and make recommendations regarding proposed legislation or policies addressing children's access to healthcare.				X
7.				
8.				
9.				
10.				

b. Current Activities

Collaboration continues with multiple state and local partners to help reduce uninsured rates. Integrating outreach and referral activities into program efforts as well as participating in the state mandated Children's Health Insurance Advisory Committee continues.

Use of the WebVISION FAMIS and PlanFirst link is ongoing with 2,223 potential eligibles identified for all programs through April of this fiscal year.

In FY 2010, five health districts used Title V funds to support clinic-based and case management efforts to identify, refer, and assist with enrollment or re-enrollment processes for publicly funded

children's health insurance programs.

The early childhood e-newsletters for FY 2010 focused on the importance of promoting social and emotional health as part of the primary care visit, as well as H1N1. The FY 2010 CCHC training included training on the medical home and health insurance for child care providers and for the children in their care. HCCV continues to work with Head Start through association meetings and the Health Advisory committee to provide relevant updates regarding health insurance programs for children. The HCCV web site received a total of 22,351 visits, a 10% increase over FY 2009.

Representatives from WIC and the Division of Child and Adolescent Health (DCAH) are participating in the Robert Wood Johnson funded Maximizing Enrollment for Kids grant awarded to the Virginia Department of Medical Assistance Services.

c. Plan for the Coming Year

Collaboration will continue with state and local stakeholders to help monitor and reduce uninsured rates. Programs which have direct contact with children and families will continue efforts to identify, refer, and assist with applications for publicly funded health insurance programs. VDH will continue to work closely with DMAS to monitor policy and program changes and disseminate information regarding these changes.

VDH will continue to implement and enhance the WebVISION-FAMIS/PlanFirst application link to identify potential eligibles for these programs. VDH will work with DMAS to provide updates, training, and technical assistance.

VDH will continue to participate in the Maximizing Enrollment for Kids grant with DMAS and other private and public sector partners. This effort encompasses multiple private and public sector partners. Partners are working on several goal groups. DCAH is serving on the "Reaching Eligible but Un-enrolled Children" work group which is currently looking at an analysis of uninsured children by age and region prepared by the Urban Institute. The group is exploring the possibility of implementing express lane eligibility concepts and practices.

Healthy Child Care Virginia (HCCV) plans to continue providing updates through representation on the Governor's Regulatory Child Day Care Council, the child care provider electronic newsletter and Head Start Health Advisory and Early Learning Council.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		30	30	30	29
Annual Indicator	31.3	32.5	32.4	32.0	33.5
Numerator	27836	28822	27881	29158	32617
Denominator	88978	88702	86033	91047	97298
Data Source				WIC program	WIC program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29	29	28	28	28

Notes - 2009
Data from WICNet, 2009

Notes - 2008
Data from WICNet, 2008

Notes - 2007
Data from WICNet, 2007.

a. Last Year's Accomplishments
The Division of Nutrition, Physical Activity, and Food Program's (NuPAFP) commitment to reduce childhood obesity continued with much attention focused on the WIC Food Package changes. The new food packages align with the 2005 Dietary Guidelines for Americans and infant feeding practice guidelines of the American Academy of Pediatrics and better meet the nutritional needs of WIC participants. The new food packages are designed to improve the nutrition and health of our nation's low-income pregnant women, new mothers, infants and young children with nutrition education and more fruits, vegetables and whole grains to greatly improve dietary quality.

In addition to focusing on implementing the new WIC Food Package, NuPAFP also worked to expand nutrition education through HealthBites, a web site providing web-based nutrition education for WIC participants and the public. Through HealthBites, WIC participants receive nutrition education credits for completing the lessons such as portion sizes, nutrition during pregnancy, breastfeeding promotion, and infant feeding. In 2009, NuPAFP contracted James Madison University to work on the conceptualization of HealthBites and defining the implementation strategy.

The Virginia WIC Program and Bright Futures focus on preventative health care and utilize anticipatory guidance to help families prepare for expected physical and behavioral changes that occur throughout their children's stages of development. In 2009, NuPAFP updated Bright Futures to emphasize child development, nutrition, physical activity, healthy weight, and mental health. Currently, VDH has developed and released updated electronic educational and resource materials providing WIC staff and other professionals with the materials they need to provide services that are consistent with Bright Futures. In addition, NuPAFP's other programs provided supplemental materials available on the Bright Futures webpage (http://healthyfuturesva.com/).

Consistent with previous years, in 2009, NuPAFP required that all health districts develop objectives in their annual WIC Services Plans to reduce childhood obesity in children ages 2-5 through utilizing state approved nutrition education curricula and materials.

In addition, NuPAFP continued its development of the Commonwealth's Healthy Approach and Mobilization Plan for Inactivity, Obesity, and Nutrition (CHAMPION) initiative through researching programs and processes for inclusion in the CHAMPION Obesity Prevention Plan. The CHAMPION Obesity Prevention Plan was released in May 2009 and provides recommended strategies and programs for creating healthy communities. Through CHAMPION, funding was made available for groups to implement nutrition education, policy, and environmental change programs. CHAMPION targets WIC children ages 2-5 through programming, policies, and initiatives available through its preschool age group.

Through a partnership with the Virginia Breastfeeding Advisory Committee, CHAMPION selected, promoted, and provided training for the Business Case for Breastfeeding. The Business Case for

Breastfeeding offers resources to help lactation specialists and health professionals to educate employers in their communities and teaches them how to successfully present the need for lactation programs to businesses. In 2010, CHAMPION held a Business Case for Breastfeeding train-the-trainer session in Richmond, VA. The training drew over 20 lactation support, public health, and healthcare professionals. From this training, a regional training was held in Southwest Virginia with approximately 20 participants.

To further childhood obesity prevention efforts in the Commonwealth, the VA Chapter of the American Academy of Pediatrics (VA AAP) has partnered with CHAMPION to create an Obesity Taskforce. Currently, CHAMPION and the VA AAP Obesity Taskforce are reviewing and selecting strategies for physician education on motivational interviewing, nutrition education, and referrals to other healthcare professionals. As one of its core strategies, CHAMPION continues to focus on healthcare providers as integral obesity prevention partners.

In addition, CHAMPION is partnering with Anthem Blue Cross Blue Shield (BCBS) and the Alliance for a Healthier Generation Healthcare pilot program in Virginia. Currently, CHAMPION is working to provide conversation starters and nutrition education materials to physicians participating in the pilot.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to promote healthy eating/healthy weight to WIC families.			X	
2. Provide educational materials on healthy weight to WIC families.			X	
3. Require district health departments to address healthy weight in their WIC Service Plans.				X
4. Review and make recommendations regarding proposed legislation or policies addressing healthy lifestyles including nutrition and physical activity issues.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Division of Nutrition, Physical Activity, and Food Program (NuPAFP) continued its commitment to reduce childhood obesity in 2010. NuPAFP focused much attention on the WIC Food Package changes which were implemented October 1, 2009. The new WIC Food Package: revises infant food packages including eliminating juice; adds fruits and vegetables; adds soy-based beverage and tofu as milk alternatives; adds whole grains (cereals, bread, and other whole grains, e.g. tortillas, brown rice); reduces some food allowances, including milk, eggs, and juice; and helps WIC more actively promote and support breastfeeding through the food packages provided to participants.

In keeping with our commitment to reduce obesity rates in our WIC children, NuPAFP continues to require that all health districts develop objectives in their annual WIC Services Plans to reduce childhood obesity in children ages 2-5 through utilizing state approved nutrition education curricula and materials.

NuPAFP also continues to expand nutrition education through HealthBites. Through HealthBites, WIC participants receive nutrition education credits for completing the lessons available in an interactive website. In 2010, James Madison University unveiled the new HealthBites format with a demonstration of the portion sizes module. All programs within NuPAFP are contributing topics for the remaining modules under development.

c. Plan for the Coming Year

In keeping with our commitment to reduce obesity rates in our WIC children, NuPAFP continues to require that all health districts develop objectives in their annual WIC Services Plans to reduce childhood obesity in children ages 2-5 through utilizing state approved nutrition education curricula and materials.

VDH and NuPAFP will continue implementation of the CHAMPION initiative through the development of a strategic state plan for obesity prevention, fostering environments for collaboration and partnerships, identifying surveillance and data resources, and promoting evidence-based interventions focused on nutrition and physical activity education, media intervention, community involvement and public policy. CHAMPION will continue to target WIC children ages 2-5 through programming, policies, and initiatives available through its preschool age group. In addition, VDH's NuPAFP will begin administering the Child and Adult Care Feeding Program (CACFP) and the Summer Food Service Program on October 1, 2010. With these two new programs, CHAMPION will have additional opportunities to provide evidence-based programs to meet the needs of young children and adolescents. CHAMPION and CACFP plan to collaborate on a CACFP Wellness Grant that would target family day homes and childcare centers through providing evidence-based curriculum, staff training, and parent education.

In the next year, VDH's NuPAFP anticipates the launch of the nutrition education modules focusing on infant and toddler feeding through the partnership with University of Virginia's Office of Continuing Medical Education. The anticipated launch of the CME site is summer 2011 to include a framework of infant and child feeding practices, a review of the developmental milestones of infant and child development with regards to feeding practices, the current epidemiology of childhood obesity and evidence-based practices in obesity prevention, and other related information.

CHAMPION will continue to focus on reducing and preventing childhood obesity through a partnership with Anthem Blue Cross Blue Shield (BCBS) and the Alliance for a Healthier Generation pilot program in Virginia. In the upcoming year, CHAMPION will continue its partnership through providing support to physicians participating in the Alliance for a Healthier Generation Healthcare initiative.

Next year, NuPAFP will continue to focus on promoting and educating WIC participants on the new WIC Food Package. In addition, all programs within NuPAFP will collaborate on content development and promotion of HealthBites to WIC participants and the public. CHAMPION plans to meet the demand from Virginians for nutrition information and obesity prevention tools through HealthBites interactive tools, as well as downloadable handouts for the public to use at events, for health promotion activities, and in support of obesity prevention activities.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		6.5	6.4	6.2	6.1
Annual Indicator	7.0	6.5	6.3	6.2	6.3
Numerator	7288	6932	6821	6637	6372
Denominator	103830	106474	108417	106578	101295
Data Source				VA Birth data	VA provisional Birth data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6	5.9	5.8	5.7	5.7

Notes - 2009
2008 provisional data. Virginia is still using the old birth certificate, so indicator measures women who ever smoked during pregnancy.

Notes - 2008
2008 final birth data. Virginia is still using the old birth certificate, so indicator measures women who ever smoked during pregnancy.

Notes - 2007
2007 data. Virginia is still using the old birth certificate, so indicator measures women who ever smoked during pregnancy.

a. Last Year's Accomplishments
Virginia General Assembly passed HB 1703 Indoor Clean Air Act which prohibits smoking in certain public buildings and restaurants.

Resource Mothers Program completed core training on the nationally-recognized Florida State University (FSU) "Partnering for a Healthy Baby". This curriculum covers topics relevant to pregnancy through the child's first three years, including the message of smoking cessation.

The Division of Women's and Infants' Health (DWIH) conducted a statewide survey of birth hospitals to assess hospital-based policy and staff orientation regarding the recommendations of the American Academy of Pediatrics (AAP) for safe sleep environment. A component of the survey was to examine smoking assessment at admission to the birth facility. Results reveal that the majority (97.2 percent) of the birth hospitals reported screening for tobacco use. Conversely, only 45.1 percent of birth hospitals reported screening for tobacco use in the place of residence of the infant. Among hospital units that screened for tobacco use, 78.3 percent reported using no specific assessment tool and 24.3 percent referred mothers to the hospital-based smoking cessation coordinator.

Virginia Healthy Start Initiative (VHSI), Resource Mothers, Family Planning, and local health department's maternity clinics assessed for tobacco use during pregnancy and the interconception period, provided smoking cessation education and counseling to women who smoke, educated women on the hazards of second hand smoke for infants and children, and

provided referrals to smoking cessation programs. In addition, all of the mentioned programs collaborated and referred pregnant women, especially teens, to the Virginia Quitline. The Quitline has established pregnant women as a priority and provides counseling and support seven days per week. More intensive treatment services are available to callers who have expressed a desire to quit smoking and enroll into a multiple session service with counselor-initiated calls. All services are available in English and Spanish. A separate TTY line is available for the hearing impaired.

In FY 2009, the Resource Mothers Program reported that 137 (12.5%) newly pregnant teens enrolled reported that they smoked early in their pregnancies. By the time of delivery 47 (34.3%) had stopped smoking.
VHSI provided case management services to 369 high-risk pregnant, postpartum, and interconception women. All women were screened for tobacco use.

Regional Perinatal Councils (RPC) initiated programs to decrease smoking during the perinatal period.
Southwest distributed 807 packets of Safe Sleep educational material to perinatal providers in the region. An additional 189 Baby Basic books and planners were distributed to practices through March 2009. Information included a Back to Sleep door hanger, light switch cover, and preterm labor information card. Northern investigated a pilot program to institutionalize safe sleep practices in three family-centered care units at Inova Fairfax Hospital as a hospital standard of care.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide guidance to women in the family planning and prenatal clinics regarding the risk of smoking.		X		
2. Provide case management to pregnant women and refer them to smoking cessation programs		X		
3. Provide smoking cessation programs through appropriate VDH programs.	X	X		
4. Review and make recommendations regarding proposed legislation or policies addressing smoking and the availability of cessation programs.				X
5. Focus all RPCs, through FIMR, to monitor smoking and to initiate smoking cessation programs sensitive to the culture of individual areas within the state.	X			X
6. Initiate evaluation of PRAMS data to provide another benchmark defining smoking within the perinatal population of Virginia.				X
7.				
8.				
9.				
10.				

b. Current Activities
2008 Virginia birth certificate data reveals that 6.2% of women self-reported smoking during pregnancy. This reflects a statistically significant downward trend in smoking rates from 8.97% in 1999 to 6.2% in 2008. Pregnancy Risk Assessment Monitoring System (PRAMS) data indicates that 10.8% of new mothers smoked in the last three months of pregnancy, 22% reported smoking prior to pregnancy, and 66% quit during pregnancy. PRAMS data also indicates that 10.8% of all

infants born in Virginia are exposed to smoke.

DWIH is facilitating the Model Program: The Most Important Modeling Job of Your Life workshops. The program is targeted for nurses in neonatal intensive care units (NICU) and well-baby units with the goal to ensure that every parent leaving a hospital is aware of and prepared to adopt safe sleep messages. The workshop addresses smoking cessation and screening for smoking in the residence.

The Virginia Department of Health partnered with the Virginia Chapter of AARP to launch "The Grandmothers Campaign for Healthy Grandchildren". This campaign underscores the importance grandmothers can play in providing commonsense advice to daughters about prenatal care and caring for a newborn, including issues pertaining to the risks of smoking.

All Resource Mothers Program sites are implementing Florida State University's "Partnering for a Healthy Baby". This curriculum covers topics relevant to pregnancy, including the message of smoking cessation.

c. Plan for the Coming Year

DWIH will evaluate the outcomes of the Model Program: The Most Important Modeling Job of Your Life train-the-trainer workshops launched by First Candle/SIDS Alliance and the National SIDS and Infant Death Program Support Center (NSIDPCS). The evaluation will include number of nurses taught the safe sleep curriculum and policy adoption or revision that took place.

DWIH, the Division of Injury and Violence Prevention, Child and Adolescent Health, and Emergency Medical System-Children are creating a plan to implement safe sleep training for emergency medical technicians. This web-based training will provide information pertaining to methods to conduct an in-home evaluation of safe sleep environment and resources available in the community to assist parents in assuring the infant is in a safe sleep environment, including effects of smoking.

DWIH is exploring the possibility of partnering with universities to initiate a program entitled "Healthy Babies Begin with You". It started several years ago from the national Office of Minority Health to address infant mortality through education at historically black colleges. Key concepts include preconception health, infant mortality, prematurity, and health disparities.

DWIH is collaborating with the Virginia Chapter of the March of Dimes and others to evaluate perinatal outcomes of the CenteringPregnancy(r) prenatal care model within Virginia by participating in the development and adoption of core outcome indicators. DWIH will also provide input and support of the development of a statewide consortium of practitioners engaged in establishing CenteringPregnancy(r) groups to share issues and lessons learned pertaining to model implementation.

Virginia has played a major role in the piloting of the text4baby service. Pregnant women register by texting a key word to the service's short code (e.g. text BABY to 311411). Once registered, the mom-to-be receive three messages per week based on her stage of pregnancy telling her what to expect, what to avoid, and what to do to help her through her pregnancy safely. After the baby is born, the new mom will receive messages based on her baby's age reminding her about important check-ups, vaccinations, and tips to keep her and her baby healthy. During the next year, evaluation and refinement of the messages is planned.

The Home Visiting Consortium will provide a web-based training on use of screening tools and group trainings across the state.

RPCs will continue projects as identified by the individual Community Action Teams in relation to

smoking risks.

The Office of Family Health Services will disseminate published PRAMS fact sheets related to safe sleep position, data tables on smoking before and during pregnancy, and infant exposure to smoke.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.4	5.4	5.2	5.2
Annual Indicator	6.4	6.2	6.2	9.5	6.6
Numerator	34	33	33	51	
Denominator	527200	528114	532781	535634	
Data Source				VA Death data & NCHS pop estimates	Trend estimate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5.2	5.2	5.1	5.1	5.1

Notes - 2009
Data for 2009 not yet available. Entry is an estimate based on trend.

Notes - 2008
2008 data from death certificates and 2008 NCHS population estimates.

Notes - 2007
2007 data from death certificates and 2007 NCHS population estimates.

a. Last Year's Accomplishments
Title V funded staff in the Division of Injury and Violence Prevention (DIVP) to provide managerial oversight to a three-year SAMHSA funded youth suicide prevention program, which ends in October 2011. The program involves school, campus, and community based approaches. Statewide gatekeeper trainings are provided using the evidence based Safe Talk and ASIST training programs. Each of the trainings has received overwhelmingly positive evaluations from participants. With support from VDH, in October 2009, the Virginia Campus Suicide Prevention Center, which is housed at James Madison University, was established to provide campus specific information, resources, and training.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote staff gatekeeper training using the evidence based ASIST, Safe Talk, and QPR programs.				X
2. Provide resources and training to initiate implementation of evidence based secondary school suicide assessment and prevention program.		X		
3. Coordinate statewide education to promote recognition of warning signs and encourage help-seeking.		X		X
4. Review and make recommendations regarding proposed legislation or policies addressing suicide prevention and access to services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DIVP staff secured participation of thirty secondary schools in Virginia in implementing the RESPONSE suicide prevention program which involves staff training, student education, and the development of response protocols. DIVP continues to provide and coordinate suicide prevention gatekeeper trainings and support youth-targeted prevention strategies in four regions in Virginia. DIVP is coordinating a series of three trainings for mental health clinicians on Recognizing and Responding to Suicide Risk (RRSR) and is working with the Department of Behavioral Health to improve the mental health system's response to suicide risk. DIVP is also currently reviewing a version of RRSR that has been developed for primary care providers and developing strategies for improving the health care response to suicide risk. DIVP is coordinating suicide prevention sessions for the annual Governor's Campus Preparedness Conference and the Virginia School and Campus Safety Conference, both to be held in summer 2010.

c. Plan for the Coming Year

DIVP will continue to provide general education and training on suicide prevention. DIVP will continue to make a concerted effort to encourage secondary schools in the Commonwealth to promote helping and help seeking for suicidal youth through evidence based models and to partner with James Madison University and the national Suicide Prevention Resource Center to encourage campuses to adopt comprehensive suicide prevention programming. DIVP will continue to partner with the Department of Behavioral Health, Department of Veterans Services, and other stakeholders to improve the primary health and mental health care response to suicide risk through education, training, and policy development. DIVP is also examining the results from a recently ended, CDC funded three-year school bullying prevention project involving over 90 schools in Virginia. Preliminary data indicates the average bullying reduction was over 20% and some schools experienced reductions of 70%. Research has found that kids who are frequently bullied in school, or who frequently bully others, are more likely to experience depression and suicidal thoughts or attempts (Klomek,et al 2007) . DIVP is working towards establishing a bullying and teen dating violence prevention position to advance these primary prevention strategies for the reduction of youth suicide and violence.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	91	91.5	91.5	92
Annual Indicator	85.2	85.3	83.9	87.6	86.9
Numerator	1191	1214	1258	1201	
Denominator	1398	1423	1499	1371	
Data Source				VA birth data	Trend estimate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	92	92.5	92.5	92.5	93

Notes - 2009
2009 data not available. Entry is an estimate based on trend analysis.

Notes - 2008
2008 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.
For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates" based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

Notes - 2007
2007 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.
For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates" based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

a. Last Year's Accomplishments
The Health Commissioner's Infant Mortality Workgroup (HCIMWG) is a diverse workgroup comprised of both lay and healthcare professionals. HCIMWG was convened to examine issues pertaining to infant mortality within Virginia. A PowerPoint presentation was created as a method to provide a consistent message pertaining to infant mortality reduction strategies, including the need for the mother to receive early and adequate prenatal care.

Through the FIMR, Maternal Death Review process and PRAMS data, entry into prenatal care is monitored, issues identified, and community-based recommendations implemented and evaluated for effectiveness.

Each Resource Mothers Program must submit a yearly plan to enhance first trimester enrollment. The enrollment activities and the birth outcomes are monitored.

VHSI local site plans include continuing and strengthening existing referral networks to identify

women early in their pregnancy and link them to services.

DWIH staff have been involved in the preliminary research and provided input into the proposed revision of obstetrical and neonatal levels of care regulations. These regulations are being compared and contrasted to the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, Guidelines for Perinatal Care, 6th Edition, (2007) and other states obstetrical and neonatal regulations.

The FIMR process includes an evaluation of the system of healthcare delivery for mothers and infants. Within the process, the RPCs have monitored obstetrical and neonatal healthcare systems to identify any issues pertaining to access to appropriate healthcare.

- West Central distributed 3,640 preterm labor literature to provider offices and health departments for use with pregnant women.
- East Central increased the awareness among health care providers, consumers, and communities in the region about the availability of 17 alpha hydroxyprogesterone caproate (17 P), the appropriate conditions for use, and the impact the drug could have in reducing preterm birth.
- Northern conducted an activity in each of the health districts to increase awareness of preterm labor signs among women of reproductive age and pregnant women in Northern Virginia.
- Eastern increased awareness of program and services available to pregnant women and improve preterm labor information given to women by providers.

Resource Mothers and VHSI staff received information pertaining to the signs and symptoms of obstetrical risk. This information empowers the Resource Mother and VHSI staff to encourage the pregnant woman to seek early, and sometimes urgent, medical care. Resource Mothers and VHSI staff are knowledgeable about obstetrical services within the communities they serve and offer direction and support for pregnant women in advocating for access to care, if necessary.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct Fetal Infant Mortality Reviews (FIMR) to identify barriers to care and make systems changes to address barriers.				X
2. VHSI local sites continue outreach to programs and clinics that provide pregnancy-testing services to increase referrals early in pregnancy.		X		X
3. The DWIH staff will serve on the regulatory work group that will review the hospital neonatal regulations during the next year.				X
4. As trending data becomes apparent through FIMR concerning access to care regional activities will occur.	X	X		X
5. Review and make recommendations regarding proposed legislation or policies addressing availability and access to appropriate care.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In Virginia, 87.6 percent of very low weight births occurred at facilities for high-risk neonates in 2007, moving toward the target of 91 percent. There is no significant increase or downward trend.

The DWIH director and policy analyst provided insight and leadership in planning the annual Association of Women Health, Obstetrical, Neonatal Nurses, Virginia Section conference held in October 2009. The focus of the conference was community involvement with perinatal women and families. Services available for women throughout the state were showcased, with referral procedures and educational resources.

All local health departments offer pregnancy testing and, if positive, provide patient counseling and referral for prenatal care within two weeks.

RPCs continue to use FIMR as a method of identifying issues pertaining to access of care. Closing of obstetrical, neonatal, and/or high-risk maternity services is confirmed with health district directors for information sharing and issues resolution. East Central is conducting a survey to assess the current use of 17 alpha hydroxyprogesterone caproate (17P) by providers and identify issues pertaining to obtaining and administering 17P.

DWIH staff continues to serve on the regulatory work group charged with the review of statewide hospital regulations, which includes the obstetrical/neonatal regulations. Technical assistance is also provided to Community Health Services in the development of the VDH standards of obstetrical care.

c. Plan for the Coming Year

RPCs will be trained and begin to document FIMR maternal interviews, case reviews, actions plans, minutes, and activities of the Community Action Teams using the Baby Abstracting System and Information Network (BASINET) web-based system. This system will provide for standardized documentation and reporting tools. These tools will be used to identify and report statewide and community issues related to smoking, prenatal care and other perinatal issues.

RPCs will continue to use FIMR as a method of identifying issues pertaining to access of care. Data pertaining to transport will be monitored. Closing of obstetrical, neonatal, and/or high-risk maternity services will be confirmed with health district directors for information sharing and issues resolution. East Central council members will provide analysis of the survey related to knowledge and utilization of 17P among perinatal healthcare providers.

DWIH and the Department of Medical Assistance Services (DMAS) will partner to investigate opportunities to expedite the provision of appropriate prenatal progesterone injections for pre-term birth in an effort to prevent recurrent preterm birth among Medicaid participants.

VHSI local sites will continue outreach services to programs and clinics that provide pregnancy-testing services to increase referrals early in pregnancy.

Discussions have begun with the Office of Minority Health and Health Policy to identify localities with suspected "near miss" and/or high levels of poor birth outcomes and limited access to key services due to either the barriers of transportation and/or limited specialty providers. Grant funding is being sought for a telehealth/medicine project.

Health departments that provide perinatal services will continue to provide education regarding the signs and symptoms of preterm labor.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	90	91	91	91	91
Annual Indicator	84.6	83.5	83.2	84.6	83.9
Numerator	88409	88867	90225	90150	85010
Denominator	104488	106474	108417	106578	101295
Data Source				VA birth data	VA provisional birth data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	91	92	92	92	92

Notes - 2007
2007 provisional birth certificate data.

a. Last Year's Accomplishments
Within the Department of Health system, 19 local health departments provide prenatal care. Health departments that do not provide prenatal care have guidelines in place to assist women obtain direct medical services with a local provider. All health departments refer those eligible to Medicaid and/or Nutrition, Physical Activity and Food Programs for services. In 2009, there were 15,878 maternity patients. This is a slight decrease (0.6%) from 15,984 patients in 2008. Overall, maternity caseload is trending upward.

RPCs led efforts to educate the healthcare community regarding the need for early and adequate prenatal care. Southwest region continued the "BABY Basics program"; the prenatal book has been provided to obstetricians in the area and funded by March of Dimes and Speedway Children's Charities. The RPC staff provides the production company input into content and revisions. BABE, Community Voices, and Centering Pregnancy(r) programs implemented by Southwest now reside with agencies in the community. West Central region continued the Beds and Britches Program, a prenatal care incentive project that rewards women for keeping prenatal appointments, active participation in childbirth education offerings, and other demonstrations of good prenatal care activities. Eastern region convened a Low Birth Weight Committee to develop a comprehensive strategy to increase awareness of the factors related to LBW births with a focus on provider and community behavior.

VHSI local sites targeted outreach to providers, programs, and clinics that provide pregnancy testing services to increase referrals early in pregnancy to assist women in accessing prenatal care. Of those enrolled in FY 2009, 86% of women entered prenatal care in the first trimester, which is above the HRSA benchmark of 75%.

Resource Mothers conducted outreach to teens and those serving teens in order to increase their awareness of the need for prenatal care in the first trimester. Of those enrolled in 2009, 65.7% were enrolled during the first trimester, which was an increase over the 2008 rate (64%) and is above the HRSA benchmark of 60% of teens enrolling in prenatal care within the first trimester; 89.2% were enrolled by the second trimester.

The Health Commissioner's Infant Mortality Workgroup (HCIMWG) is a diverse workgroup comprised of both lay and healthcare professionals. HCIMWG was convened to examine issues pertaining to infant mortality within Virginia. At each HCIMWG meeting, education is provided to the members on issues pertaining to perinatal health. Topics included, but were not limited to health disparities within Virginia, Centering Pregnancy(r), and the March of Dimes prematurity campaign. A PowerPoint presentation including information that supports the need for the mother to receive early and adequate prenatal care is available for members to use when providing education to community groups.

Through the FIMR, Maternal Death Review process, and PRAMS data, entry into prenatal care is monitored, issues identified, and community-based recommendations implemented and evaluated for effectiveness.

Each Resource Mothers Program must submit a yearly plan to enhance first trimester enrollment. The enrollment activities and the birth outcomes are monitored.

VHSI local site plans include continuing and strengthening existing referral networks to identify women early in their pregnancy and link them to services.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Educate providers on how to better serve low income women and link them to community resources including health insurance.		X		
2. Educate public on the importance of early prenatal care.			X	
3. Provide education and training to providers on topics that support adequate prenatal care.		X		
4. Provide funding to district health departments to support prenatal care.		X		
5. Through the FIMR and Maternal Death Review process, entry into prenatal care will be monitored, issues identified and community-based recommendations implemented and evaluated for effectiveness.		X		
6. VHSI local sites continue outreach to programs and clinics that provide pregnancy-testing services to increase referrals early in pregnancy. Referral systems established with Medicaid eligibility workers, Community Health Centers, health department	X			
7. Review and make recommendations regarding proposed legislation or policies addressing access to care.				X
8.				
9.				
10.				

b. Current Activities

The percent of infants born to women who received prenatal care in the first trimester, with the target being 91%, has reflected a statistically significant downward trend from 84.7% in 1999 to 84.6% in 2008.

All local health departments offer pregnancy testing and, if positive, provide patient counseling and referral for prenatal care within two weeks.

RPCs are initiating programs to increase early entry into prenatal care. Southwest region is working to increase awareness of obstetrical providers in the availability of 211 as an information and referral source for their clients.
West Central region is developing a webpage with Thomas Jefferson Health District to provide a list of resources and services for women and children.

Each Resource Mothers Program submits a yearly plan to enhance first trimester enrollment. The enrollment activities and the birth outcomes are monitored.

Due to its collaborative structure that utilizes home visiting strategies to establish linkages among health, child care, and other community resources to better serve families, the Virginia Home Visiting Consortium presented on a national webinar sponsored by Chapin Hall on the new federal legislation regarding home visiting on September 9, 2009.

c. Plan for the Coming Year
The Home Visiting Consortium is encouraging local home visiting programs to join together to publicize their services to providers and inform them on how to make a referral to a central location. A referral form that meets the requirements for HIPAA, FERPA, and 42CFS was developed and approved by the Attorney General for provider use and centralized intake centers will be encouraged to adopt the form.

RPCs in Southwest continue to educate providers about the 211 information and referral source. The goal is to identify missing providers and services that need to be listed in the 211 database. Southwest will continue the Baby Basics Moms Club at Bristol Regional Medical Center (BRMC). West Central will evaluate a web page with Thomas Jefferson Health District to provide a list of resources and services for women and children. East Central will continue to work with birth centers in the region to increase access to perinatal care.

All local health departments will offer pregnancy testing and, if positive, provide patient counseling and referral for prenatal care within two weeks.

The Home Visiting Consortium will continue to work with local Smart Beginnings Coalitions to publicize the availability of home visiting services for families with moderate or high risk factors, and to develop local centralized intake processes

To increase access to early prenatal services, a pilot project has begun with Emergency Room (ER) Departments of Virginia Commonwealth University, Mary Washington Hospital, and Sentara Hospital System. All women diagnosed as pregnant during the ER visit will be provided with a completed Pregnancy Verification Form, which is required with the submission of Medicaid and FAMIS PLUS applications. In addition, all women will be provided information at discharge regarding public assistance programs and directions on how to apply. It is hoped by 2012 that this will become standard practice in all ER departments and that prior to discharge from the ER, the first prenatal appointment will have been scheduled.

The Health Commissioner's Multivitamin Counseling and Distribution Program, based upon the North Carolina Folic Acid Council Campaign, will distribute and educate childbearing-age women who seek services at local health departments about the role of folic acid in reduction of birth defects. A training video, which is in production, will be used to train nurses and other key staff.

D. State Performance Measures

State Performance Measure 1: *The percent of children and adolescents who have a specific source of ongoing primary care for coordination of their preventive and episodic health care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84	84	84	84	84
Annual Indicator	85.1	85.1	85.1	92.5	92.5
Numerator				1689036	1689036
Denominator				1826259	1826259
Data Source				National Survey of Children's Health	National Survey of Children's Health
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	84	85	85	85	

Notes - 2009
Data from the National Survey of Children's Health released 2009.
Question:
Do you have one or more person(s) you think of as your child's personal doctor or nurse ?

Notes - 2008
Data from the National Survey of Children's Health released 2009.
Question:
Do you have one or more person(s) you think of as your child's personal doctor or nurse ?

Notes - 2007
Estimate based on data from the National Survey of Children's Health released 2005.
Question:
Do you have one or more person(s) you think of as your child's personal doctor or nurse ?(S5Q01)

a. Last Year's Accomplishments
In FY 2009, OFHS funded health districts that promote access to medical homes through case management, assistance with getting and using public health insurance programs, and, in some districts, provision of child health services for clients with no other resources. Alexandria, Cumberland Plateau, Norfolk, Piedmont, Roanoke, and Virginia Beach are using Title V funds to work on these goals.

VDH programs such as VEHDI, VNSS, and Care Connection for Children (CCC) continued efforts to link newborns to medical homes as needed.

Healthy Child Care Virginia (HCCV) electronically reposted the 2009 newsletter for child care provider professionals with information devoted to children's health insurance programs and the importance of a medical home.

The Division of Child and Adolescent Health (DCAH) participated in the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC). The DCAH Director served on a work group focused on promoting medical home and a system of care for CSHCN identified through newborn screening. NYMAC issued mini grants to implement primary and specialty care providers' roles in serving as medical homes for CSHCN.

The Virginia CSHCN Title V program was awarded a HRSA State Implementation Grant for Integrated Community Systems for CSHCN which started in June 2009. Although the grant focus is on CSHCN, several medical home grant objectives are planned that should strengthen the medical home model in Virginia overall.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fund local health districts to assist families in finding and utilizing a medical home.		X		
2. Participate in initiatives and coalitions that aim to increase utilization of medical homes.				X
3. Continue surveillance, monitoring, and dissemination of data related to utilization of care.				X
4. Work with the AAP to promote the medical home concept for all children and adolescents.				X
5. Work with school nurses to promote the medical home concept to school children and their parents.				X
6. Collaborate with state Early Childhood Comprehensive Systems Project to implement a strategic plan for assurance of medical and dental homes.				X
7. Review legislation and policies addressing health care access.				X
8. Continue participation in the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services to promote medical homes for CSHCN.				X
9.				
10.				

b. Current Activities

VDH Title V staff continue to promote medical home concepts in all partnerships. VDH and the AAP, in partnership with James Madison University, launched the Bright Futures web site (www.healthyfuturesva.com). This site uses short videos to personify the anticipatory guidance themes and well child visits. The site covers key themes around child development, oral health, and healthy weight/nutrition and visits through age four. The site is near completion, with all additional themes and visits slated to be live by July 2010.

Healthy Child Care Virginia (HCCV) e-newsletters for FY 2010 focused on the importance of promoting social and emotional health as part of the primary care visit and H1N1. The FY 2010 CCHC training included training on the medical home and health insurance for child care providers and for the children in their care. HCCV continues to work with Head Start through association meetings and the Health Advisory committee to provide updates regarding children's health insurance programs. The HCCV web site received a total of 22,351 visits, a 10% increase over FY 2009.

DCAH programs continue efforts to link newborns to medical homes. DCAH is working on integrating follow up across newborn screening programs. Information will be shared to increase follow up cases with an identified primary care provider and streamline communications to providers.

DCAH staff continue to participate in the NYMAC work group on promoting the medical home.

c. Plan for the Coming Year
VDH will continue to promote the concept of the medical home in all DCAH programs and partnerships. The Bright Futures web site will be maintained.

DCAH staff will continue to participate in the NYMAC medical home efforts.

Healthy Child Care Virginia (HCCV) plans to continue providing updates through representation on the Governor's Regulatory Child Day Care Council, the child care provider electronic newsletter, and Head Start Health Advisory and Early Learning Council meetings.

As part of the CSHCN Virginia Systems Improvement Project, training on the medical home will be provided for home visitors across the state in FY 2011. This training will provide uniform training to home visitors from 13 programs in understanding and supporting medical homes and include activities to help home visitors facilitate complete and effective communication between their clients and their medical providers. A survey on current statewide medical home initiatives will be completed. This project will also support a learning collaborative on medical home for 15 primary care practices (including a range of federally qualified health centers). This collaborative will reach across geographic areas of the state. Though targeted toward improving systems for CSHCN, the promotion of medical home in practice will benefit all children served.

State Performance Measure 2: *The percent of children who are overweight or obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	14	14	14	14
Annual Indicator	31.3	32.5	32.4	32.0	33.5
Numerator	27836	28822	27881	29158	32617
Denominator	88978	88702	86033	91047	97298
Data Source				WIC data	WIC data
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	14	13	13	13	

Notes - 2009
Data from the WIC program database WICNet 2009. Beginning in 2004, overweight/obese was defined as at or above the 85th percentile. Previously, the 90th percentile was reported, so data prior to 2004 are not comparable to current figures.

Notes - 2008
Data from the WIC program database WICNet 2008. Beginning in 2004, overweight/obese was defined as at or above the 85th percentile. Previously, the 90th percentile was reported, so data prior to 2004 are not comparable to current figures.

Notes - 2007
Data from the WIC program database WICNet 2007. Beginning in 2004, overweight/obese was defined as at or above the 85th percentile. Previously, the 90th percentile was reported, so data prior to 2004 are not comparable to current figures.

a. Last Year's Accomplishments
The Division of Nutrition, Physical Activity, and Food Program's (NuPAFP) commitment to reduce childhood obesity continued in 2009. NuPAFP worked to expand the nutrition education component of WIC through HealthBites, a web site providing web-based nutrition education for WIC participants and the public. HealthBites has information to help busy families make healthful

food choices through web-based, interactive learning. In 2009, NuPAFP contracted with James Madison University to work on the conceptualization of HealthBites and defining implementation strategies.

The Virginia WIC Program and Bright Futures focus on preventative health care and utilize anticipatory guidance to help families prepare for expected physical and behavioral changes that occur throughout children's stages of development. In 2009, NuPAFP updated Bright Futures to emphasize child development, nutrition, physical activity, healthy weight, and mental health. Currently, VDH has developed and released updated electronic educational and resource materials providing WIC staff and other professionals with the materials they need to provide services that are consistent with Bright Futures. In addition, NuPAFP's other programs have provided supplemental materials available on the Bright Futures webpage (http://healthyfuturesva.com/).

In addition, NuPAFP continued its development of the Commonwealth's Healthy Approach and Mobilization Plan for Inactivity, Obesity, and Nutrition (CHAMPION) initiative through researching programs and processes for inclusion in the CHAMPION Obesity Prevention Plan. The CHAMPION Obesity Prevention Plan was released in May 2009 and provides recommended strategies and programs for creating healthy communities. Through CHAMPION, funding was made available for groups to implement nutrition education, policy, and environmental change programs. CHAMPION targets WIC children ages 2-5 through programming, policies, and initiatives available through its preschool age group.

With the release of the CHAMPION Plan in May 2009, VDH and NuPAFP began implementation through providing grant funding to community groups in areas with the highest obesity prevalence in the Southwest and Hampton Roads areas. Funding was available for community groups to implement evidence-based programs that are proven effective, low-cost, and take the first step in creating healthier communities in the Commonwealth. Through the first grant cycle, nin grants were awarded reaching approximately 960 parents and caregivers, 1,770 children and adolescents, 23 worksites, 450 employees, and 50 lactation specialists. CHAMPION has begun the second stage of implementation through regional reengagement meetings at the remaining four regions: Central, Roanoke, Blue Ridge, and Northern Virginia. These regions have been given the opportunity to apply for grant funding to implement evidence-based, low-cost programs in the next year.

Created in July 2009, the Virginia Foundation for Healthy Youth (VFHY) has quickly become one of VDH's and CHAMPION's strongest partners. The VFHY, formerly the Virginia Tobacco Settlement Foundation, focuses on preventing and reducing childhood obesity and youth tobacco usage. VDH's CHAMPION Obesity Program helped plan and participated in the General Assembly Healthy Youth Day on January 20, 2010 to promote physical activity and health with Virginia's legislators. Over 250 public school children participated in the event and Virginia's first lady, Maureen McDonnell, provided the keynote address. CHAMPION provided pedometers for each of the participants and demonstrated to the youth how to use the pedometers to track daily physical activity. The 2010 General Assembly passed a resolution in March 2010 making the event an annual occurrence. VDH's CHAMPION program is also sponsoring the 2010 Weight of the State conference and has served on the conference planning committee.
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide educational materials promoting healthy lifestyles.			X	
2. Participate in coalitions and collaborations aimed at policy and program development to promote healthy nutrition and adequate physical activity.				X

3. Support activities of Virginia Action for Healthy Kids to improve access to healthy foods and increased physical activity opportunities within schools.				X
4. Promote "Eat Smart Virginia", an obesity prevention tool kit.			X	
5. Collaborate with the Department of Education to maintain the website "Health Smart Virginia."		X		
6. Fund and support local health district programs that address childhood obesity.		X		
7. Review and make recommendations regarding policies/legislation addressing obesity.				X
8. Develop and distribute the CHAMPION Report based on the regional meetings addressing prevention and control of obesity.				X
9. Develop and maintain a CHAMPION web site.			X	
10.				

b. Current Activities

Through a partnership with the Virginia Breastfeeding Advisory Committee, CHAMPION selected, promoted, and provided training for the Business Case for Breastfeeding. The Business Case for Breastfeeding offers resources to help lactation specialists and health professionals educate employers in their communities. The training teaches them how to successfully present the need for lactation programs to businesses. In 2010, CHAMPION held a Business Case for Breastfeeding training in Richmond, VA drawing over 20 lactation support, public health, and healthcare professionals. From this training, a regional training was held in Southwest Virginia with approximately 20 participants.

NuPAFP continues to expand nutrition education through HealthBites, a web site providing web-based nutrition education for WIC participants and the public. In 2010, James Madison University unveiled the new HealthBites format with a demonstration of the portion sizes module. All programs within NuPAFP are contributing topics for the remaining modules under development.

To further childhood obesity prevention efforts in the Commonwealth, the VA Chapter of the American Academy of Pediatrics (VA AAP) is creating an Obesity Taskforce. Currently, CHAMPION and VA AAP Obesity Taskforce are reviewing and selecting strategies for physician education on motivational interviewing, nutrition education, and referrals to other healthcare professionals.

c. Plan for the Coming Year

CHAMPION continues to focus on reducing and preventing childhood obesity through a partnership with Anthem Blue Cross Blue Shield (BCBS) and the Alliance for a Healthier Generation pilot program in Virginia. As part of the Alliance for a Healthier Generation pilot program, Anthem will offer extra-contractual healthcare benefits for the prevention and treatment of childhood obesity through three additional visits with a physician and registered dietitian for children with a BMI greater than the 85th percentile. Currently, CHAMPION is working with the Alliance for a Healthier Generation to provide conversation starters and nutrition education materials to physicians participating in the pilot.

As part of CHAMPION's obesity prevention initiative, VDH and NuPAFP plan to continue to provide grant funding statewide for the implementation of CHAMPION recommended programs. In addition, NuPAFP will continue to fulfill training and technical assistance requirements to mini-grant recipients. Each grant recipient will receive training in their selected program as well as on-going technical assistance throughout the contract period. In addition, NuPAFP will begin analyzing the programs implemented through CHAMPION in Virginia to determine each program's effectiveness and success in the Commonwealth.

VDH and NuPAFP will continue its implementation of CHAMPION by seeking opportunities for collaboration and partnerships to strengthen statewide obesity prevention efforts through encouraging policy and environmental changes at the local levels, increasing awareness and education around overweight and obesity prevention, and promoting evidence-based interventions.

A planned partnership for the upcoming year will be with the Child and Adult Care Feeding Program (CACFP) and the Summer Food Service Program (SFSP). These programs, previously administered by the United States Department of Agriculture (USDA) regional office, will be administered by NuPAFP beginning October 1, 2010. CACFP and SFSP present an opportunity to expand obesity prevention tools and policies to child and adult care programs statewide and reach additional at-risk populations.

In the next year, VDH, through multi-sector partnerships, will focus on the expansion of the CHAMPION obesity prevention program through implementation of the ARRA CPPW grant through providing local funding, training, and policy and environmental change strategies to create healthier communities statewide.

State Performance Measure 3: *The percent of newborns who fail the hearing screening and who receive a diagnosis before three months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	89	93	95	74
Annual Indicator	71.9	68.9	70.3	65.5	63.6
Numerator	2158	1940	1996	2029	1776
Denominator	3001	2815	2840	3098	2792
Data Source				VA EHDI program	VA EHDI program
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	85	89	93	

Notes - 2009
The measure was changed for the 2008 Title V Application. The previous measure read: "The percent of newborns screened for hearing loss who receive recommended follow-up services." This measure definition applies to data years 2005 and previous.

The new measure emphasizes the need not only for a follow-up visit but for a diagnosis (hearing loss, normal hearing, etc.) within three months.

Data are from the Virginia Early Hearing Detection and Intervention Program.

Notes - 2008
The measure was changed for the 2008 Title V Application. The previous measure read: "The percent of newborns screened for hearing loss who receive recommended follow-up services." This measure definition applies to data years 2005 and previous.

The new measure emphasizes the need not only for a follow-up visit but for a diagnosis (hearing loss, normal hearing, etc.) within three months.

Data are from the Virginia Early Hearing Detection and Intervention Program.

Notes - 2007
The measure was changed for the 2008 Title V Application. The previous measure read: "The percent of newborns screened for hearing loss who receive recommended follow-up services." This measure definition applies to data years 2005 and previous.

The new measure emphasizes the need not only for a follow-up visit but for a diagnosis (hearing loss, normal hearing, etc.) within three months.

Data are from the Virginia Early Hearing Detection and Intervention Program.

a. Last Year's Accomplishments
During FY 2009, the VEHDI Program carried out several initiatives to improve the percentage of infants receiving a diagnosis by three months of age. A tracking and follow-up plan for VEHDIP staff was devised and implemented. VEHDIP staff continued to generate letters to parents and primary care providers for infants who failed the initial screening urging timely follow up and offering resource information. Infants diagnosed with hearing loss were referred to the state early intervention program at the Virginia Department of Behavioral Health and Developmental Services (DBHDS).

VEHDI staff and external stakeholders participated in a national learning collaborative with the National Initiative for Children's Health Care Quality (NICHQ). Protocols for hospitals and audiologists were reviewed and a revision process was initiated.

Data improvement and reporting application development and testing activities were conducted in collaboration with the VDH Office of Information Management (OIM) in preparation for the release of the Virginia Infant Screening and Infant Tracking System (VISITS) II. System development included activities related to preparation to link to the Electronic Birth Certificate (EBC). Other data improvement activities included incorporating the ability to report hearing screenings for infants not born in Virginia hospitals.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Administer statewide early hearing detection and intervention program.			X	
2. Mail letters to parents and primary care providers regarding screening results and need for follow up.	X			
3. Implement aggressive tracking activities for children lost to follow-up.	X			
4. Collaborate with Part C Early Intervention System to streamline referrals and document outcomes.				X
5. Provide parent-to-parent contact for families of children with hearing loss.		X		
6. Provide training to increase capacity of Part C Early Intervention System to provide appropriate intervention services for children with hearing loss.				X
7. Maintain the Virginia Hearing Aid Loan Bank.	X			
8. Review any proposed legislation and policies that address newborn hearing services.				X
9. Maintain the Guide By Your Side Program.	X			
10.				

b. Current Activities
In FY 2010, the VEHDI Program is building follow up efforts through improved data quality and reporting, collaboration with stakeholders, public awareness, and family-to-family support initiatives.

A revised 1-3-6 Follow Up Plan is being implemented. Protocols for primary care providers, audiologists, and hospitals continue to be revised with 2007 JCIH recommendations and proposed state regulation changes. The audiological evaluation form is being revised for American Speech-Language-Hearing Association (ASHA) guidelines. Audiologist survey results from both a VEHDIP statewide survey as well as one recently conducted by the National Center for Hearing Assessment and Monitoring (NCHAM) have been analyzed for recommendations to improve the audiology work plan and participation in newborn hearing screening. Six hospital site visits are planned to improve follow up and primary care provider identification. Virginia Learning Collaborative activities have been initiated with three pediatric and three audiology practices.

VISITS II was released in April 2010 as part of the VVESTS system. Follow up documentation, data quality, ability to extract follow up data, and sharing of follow up information with bordering states is improved. A tracking system is in place to address hospital user suggestions.

VEHDI staff recently participated in a site visit on May 12, 2010 with the CDC.

c. Plan for the Coming Year
During FY 2011, VEHDI Program staff will continue collaborative efforts with multiple stakeholders to improve timely and complete follow up.

VEHDI staff will develop, pilot test, and post two 30 minute online modules for primary care providers. In collaboration with other stakeholders, an EHDI on-line training for early intervention providers will be developed. A midwife survey will be developed, completed, and evaluated to help improve participation by this group. The feasibility of engaging OB/GYNs in the EHDI process will be evaluated. Findings from the Virginia Learning Collaborative will also be incorporated into program practice and protocols. VEHDI advisory committee members plan to visit and encourage three military facilities to report hearing screening results.

VEHDI staff will work with OIM to make improvements to VVESTS to assist with follow up activities and quality data reporting. Data as well as system operations will continue to be evaluated and enhanced as needed.

The VEHDI Program will continue to be promoted statewide. Public awareness activities planned include distributing the Loss & Found DVD to hospital nurseries and PCP offices and initiating a Public Service Announcement awareness campaign in two major regions.

The revised 1-3-6 follow-up process will also undergo repeated monitoring for evaluation of improvement. Collaboration with other state agencies will continue to locate a permanent home for the Hearing Aid Loan Bank and the Virginia Guide By Your Side Program.

An EHDI Communications and Awareness Plan is being developed with hearing screening contact information being promoted through social media outlets. A data exchange agreement is being negotiated with the state Part C program. The Virginia Hearing Aid Loan Bank and the Guide by Your Side programs continued as part of family-to-family support.

State Performance Measure 4: *The unintentional injury hospitalization rate for children aged 1-14 per 100,000.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	135	132.5	130	130	130
Annual Indicator	121.4	124.9	121.0	112.1	112.7
Numerator	1704	1732	1697	1573	
Denominator	1403893	1387023	1402502	1403603	
Data Source				VA hospital discharge data	Trend estimate
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	130	130	130	129	

Notes - 2009
2009 data not yet available. Entry is an estimate based on trend.

Notes - 2008
Data from Virginia Hospitalization Discharges 2008.

Notes - 2007
Data from Virginia Hospitalization Discharges 2007.

a. Last Year's Accomplishments
Title V funded staff in the Division of Injury and Violence Prevention (DIVP) to provide oversight for, and coordination of, the statewide unintentional injury prevention program and to leverage multiple sources of federal funding support for activities. DIVP fulfilled requests for 621,445 individual pieces of educational material (brochures, videos on a variety of childhood injury topics) through the Injury Prevention Resource Center.

DIVP staff continued to co-chair a statewide planning group as part of a CDC cooperative agreement. DIVP staff published the annual report on injury deaths and hospitalizations in Virginia. DIVP maintained the Virginia Online Injury Reporting System (VOIRS), an online reporting system allows the user to create customized injury data reports on various causes and intents of injury by geographic and demographic variables. The system now has death and hospitalization injury data from 1999-2007.

DIVP staff utilized Preventive Health Services (PHHS) Block Grant funding to support community injury prevention projects to address poisoning, falls, drowning and suffocation. Last year, these projects impacted over 15,000 children. In 2009, PHHS funding also enabled DIVP to provide 60 local organizations throughout the Commonwealth with mini-grants to purchase bike helmets as part of a project to promote proper helmet usage and bicycle safety that resulted in approximately 9,353 children being properly fitted for helmets and participated in bike safety educational sessions.

DIVP staff managed a statewide fire prevention education and smoke alarm installation project as part of a CDC cooperative agreement. During 2009, this project was implemented in six communities in Virginia. Since the beginning of this project in 1998, approximately 54,165 smoke alarms have been installed with over 117 lives documented as being possibly saved or injures averted.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate state, community and school based educational activities relating to the prevention of unintentional injuries.			X	
2. Provide funding and support for health districts' unintentional injury projects.		X		
3. Develop and implement public awareness campaigns.			X	
4. Disseminate safety devices (e.g. child restraints, smoke alarms).	X			
5. Review and make recommendations regarding proposed legislation or policies addressing unintentional injury issues.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DIVP staff continue to coordinate numerous state and community childhood injury prevention projects and to provide data, educational resources and information through a website, resource center, and 1-800 line. DIVP has produced an annual report on injury deaths and hospitalizations that occurred in 2008, the most recent year available, and has updated the Virginia Online Injury Reporting System with 2008 data. DIVP produced an injury update report on sports related injuries among children with an emphasis on sports-related concussions.

DIVP staff continues to coordinate a statewide injury prevention planning process, funded through a CDC cooperative agreement, and will be holding an Injury Prevention Symposium in July to promote injury prevention throughout Virginia. DIVP staff also continues to manage a statewide fire prevention education and smoke alarm installation project as part of a CDC cooperative agreement.

DIVP staff are utilizing Preventive Health and Health Services (PHHS) Block Grant funding to support community injury prevention projects to address the leading causes of unintentional injury related death and hospitalization in Virginia.

c. Plan for the Coming Year

DIVP plans to continue to coordinate a wide variety of state-level and community-level activities to prevent childhood injuries. DIVP will continue work to provide technical assistance and consultation in all areas of unintentional injury prevention with an emphasis on general injury prevention outreach, education, and policy work; child passenger safety; fire and burn prevention; and traumatic brain injury prevention.

DIVP is working to support the implementation of countermeasures that are proven to prevent and/or minimize the severity of brain injuries such as proper surfacing material on playgrounds, head protection, early recognition of a head injury, and proper treatment especially in sporting situations. DIVP partnered with the Brain Injury Association of Virginia to conduct a public awareness campaign on concussion and the importance of prevention and treatment. DIVP is partnering with the Department of Education to add concussion information into the mandatory training required of high school coaches and support their activities in response to 2010 General Assembly legislation requiring schools to develop guidelines regarding the management of

concussion among student athletes. DIVP will initiate projects to raise the awareness of healthcare providers, athletes, coaches and parents about the prevention of sports related concussions through behavior changes, the proper use of headgear, the recognition and treatment of injuries and return to play decisions.

DIVP continues to expand its efforts to promote safe sleeping environments for infants. The Division has begun working with local health departments from southwestern Virginia to address the high rates of suffocation and SIDS/SUIDS in this region.

In an effort to improve services to communities that have great need and are often difficult to reach, DIVP is contracting 12 focus groups throughout the Commonwealth of Virginia. These focus groups will provide insight into the safety-related health promotion needs of these communities and the most effective way to promote key messages to these audiences. The findings will be used to improve injury prevention educational materials that DIVP develops for parents and caregivers of infants and toddlers. The focus groups will be conducted in four separate regions of the state and will consist of three low income communities, three Spanish speaking communities, and three targeting the largest minority/culture group in that particular region.

DIVP is in the initial stages of coordinating a drowning prevention campaign, in conjunction with local Safe Kids coalitions, local health departments and other stakeholders, to draw attention to pool safety and the recommendations for public and residential pool and spa owners to replace drain covers with covers compliant with the Virginia Graeme Baker Act to reduce suction and entrapment fatalities and injuries.

State Performance Measure 5: *The percent of low income children (ages 0-5) with dental caries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12.5	12.4	12.3	12.2
Annual Indicator	22.2	22.3	21.3	21.1	17.8
Numerator	2763	2923	2761	2715	2327
Denominator	12456	13087	12938	12887	13091
Data Source				Head Start Data	Head Start Data
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12.1	12	11.9	11.9	

Notes - 2009
FY09 Head Start Data; State FY 7/1/08-6/30/09

Notes - 2008
FY08 Head Start Data; State FY 7/1/07-6/30/08

Notes - 2007
FY07 Head Start Data; State FY 7/1/06-6/30/07

a. Last Year's Accomplishments
The Division of Dental Health (DDH) supported local health department dental programs with a dentist to coordinate a quality assurance program, assisting with recruitments for local health

department dental programs, and orienting new dental staff. Training was provided for 100 dental staff in 25 health districts regarding pediatric dentistry and other public health dental topics. On-site quality assurance clinic reviews were provided for dental programs in Henrico, Danville, Central Shenandoah, Central Virginia, Prince William and Loudoun Health Districts. In FY 2009, VDH dental clinics provided 39,500 visits for individuals in more than 149,000 clinical services with a value of nearly $13 million dollars. Almost 12% of visits were for preschool children up to four years old and more than 5,000 visits included fluoride varnish treatments. Central Shenandoah, Cumberland Plateau, Norfolk, Peninsula, Piedmont, Roanoke, Thomas Jefferson, Western Tidewater and Central Virginia used Title V funds to help support their dental programs and provide comprehensive dental care (treatment and prevention, including fluoride varnish).

c This opportunity to expand the existing program has provided a much needed emphasis on improving access to dental services for very young children who are at high risk for dental disease. Bright Smiles for Babies, the DDH fluoride varnish program, grew in FY 2009 with additional funding from Preventive Health and Health Services (PHHS) Block Grant. Services including assessment and varnish were provided to 6,534 children in FY 2009. PHHS also funded a part time coordinator to work with Children with Special Needs and oral health related activities as of FY 2009.

Nearly six million citizens, including children of preschool age, consume water that has been optimally fluoridated. DDH staff continues to work with the Department of Medical Assistance Services regarding fluoride varnish reimbursement issues and serve on the statewide Head Start Advisory Committee.

In 2009, "Oral Health Care for Children with Special Health Care Needs (CSHCN)" trainings were provided to four Care Connection for Children sites including Blue Ridge, Central VA, Hampton Roads, and Southwest Virginia. Training was also provided to the Child Development Services Program Clinic in Southwest and to the staff at the Children's Hospital in Richmond. Through a contract funded by TOHSS, Virginia Commonwealth University (VCU) School of Dentistry provided advanced training to 70 dentists to increase their skills in treating young children and CSHCN to date.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide anticipatory guidance for parents.		X		
2. Provide fluoride varnish application for children.	X			
3. Maintain data collection efforts for evaluation of dental programs.				X
4. Provide training for dental providers.		X		
5. Collaboration with Medicaid regarding covered services.		X		X
6. Collaboration with partners (i.e. WIC, Early Head Start, Head Start) to provide anticipatory guidance or other oral health services.		X		
7. Oral health services are provided to children 0-5 in local health department dental clinics.	X			
8. Review and make recommendations regarding proposed legislation or policies addressing access to dental care.				X
9.				
10.				

b. Current Activities

Between July 1 and December 30, 2009 local health districts provided 2,343 visits for children under four years old and 2,879 fluoride varnish applications. To date in FY 2010, 4,208 children enrolled in WIC have received assessment, fluoride varnish and parental questionnaire by staff funded through the TOHSS and PHHS Grants. The program has been implemented in Chesterfield, Henrico, Richmond, Three Rivers, Lord Fairfax, Southside, Piedmont, Rappahannock, Hampton, Peninsula, Eastern Shore, and Hanover Districts. Individual risk-based information was provided regarding daily oral hygiene, nutrition, feeding practices, fluoride, the importance of primary teeth and dental home. Baseline data is continuing to be collected using the Basic Screening Survey.

DDH developed a web site in 2008 to identify dentists who will care for patients with special needs. The web site is currently being updated through a survey for dentists with cooperation from the Virginia Dental Association.

A questionnaire was developed and used to assess the oral health care needs of CSHCN, the oral health knowledge of the families, and their ability to access dental care for their child. This information will be used to develop additional resources and plan programs for this population. Additional trainings for dentists to treat CSHCN and young children have been scheduled for later this year.

c. Plan for the Coming Year

DDH will be working to finalize the data and work on sustainability of the services provided through the last year of the TOHSS grant. DDH will continue to collaborate with other providers of services to young children such as Head Start and Early Head Start through serving on the state advisory committee and working with local programs.

In addition to this continued focus on providing services for young children at risk, additional efforts will be continued to educate and train providers and caregivers regarding the oral health of CSHCN.

State Performance Measure 6: *The ratio of dentists to population in underserved areas.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		0.4	0.5	0.6	0.7
Annual Indicator	0.3	0.3	0.3	0.3	0.3
Numerator	1318	950	950	950	
Denominator	4290110	3690512	3690512	3690512	
Data Source				VA Manpower Survey	Trend estimate
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0.8	0.8	0.8	0.8	

Notes - 2009

Estimate based on 2006 Manpower Survey

Notes - 2008
Data is from a 2006 VDH assessment of dentally underserved areas in Virginia and Manpower Analysis. The annual indicator represents the number of general dentists per 1,000 population, where the numerator is the number of general dentists in all dentally underserved areas and the denominator is the total population of all dentally underserved areas in Virginia. The statewide average dentist to population ratio is 1 dentist per 2,472 persons or ~0.5 dentists per 1,000 persons. Areas of need are defined as those areas having a lower dentist to population ratio than the statewide average, and need at least 0.5 additional dentists to meet the state dentist to population ratio.

Notes - 2007
Data is from a 2006 VDH assessment of dentally underserved areas in Virginia and Manpower Analysis. The annual indicator represents the number of general dentists per 1,000 population, where the numerator is the number of general dentists in all dentally underserved areas and the denominator is the total population of all dentally underserved areas in Virginia. The statewide average dentist to population ratio is 1 dentist per 2,472 persons or ~0.5 dentists per 1,000 persons. Areas of need are defined as those areas having a lower dentist to population ratio than the statewide average, and need at least 0.5 additional dentists to meet the state dentist to population ratio.

a. Last Year's Accomplishments
Early in FY 2009 due to budget cuts, the state general funding was lost for both the Dental Scholarship and Loan Repayment programs. Revenue funds were also lost (financial obligation paid back by dentists who decided not to serve in an area of need). The Virginia Dental Scholarship Program had been in place since 1952 and the Loan Repayment program was first implemented during FY 2006. Both programs have been funded by state general funds.

DDH funded dental hygienists for loan repayment awards for the second year using state general funds. Regulations for the program were under periodic review.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Dental scholarship program for dental students.		X		
2. Provide dental loan repayment program for practicing dentists and dental hygienists.		X		
3. Collaborate with the Office of Health Policy on designation of dental Health Professions Shortage Areas.				X
4. Maintain collaboration with Virginia Commonwealth University's School of Dentistry.				X
5. Recruit dentists to serve in local health departments.				X
6. Analyze data on Medicaid patients seen in underserved areas.				X
7. Review and make recommendations regarding proposed legislation or policies addressing dental practice issues.				X
8. Continue to market the loan repayment programs.				X
9. Update the designation of dental areas of need according to regulation.				X
10.				

b. Current Activities
Currently thirteen dentists are still being tracked for their loan repayment or scholarship contract obligations. One additional recipient is still in dental school and will graduate in 2010. Nine

dental hygienists are being tracked for loan repayment. General funds for the Dental Hygienist Loan Repayment were also eliminated in this year's budget reduction.

Although funding is no longer in place for this program, DDH will continue to conduct a manpower analysis as required by regulation. Until that analysis is completed in 2011, trends will not change for this indicator. DDH is also currently conducting the periodic review of the regulations for this program, which is still in Code, although not funded.

DDH was awarded a HRSA "Grants to Support Oral Health Activities" starting in 2010 that will provide four state or federal public health dentists with loan repayment if they practice in a state or federal dental shortage area. This program is much more restrictive than the state program and will not assist any private practice dentists in loan repayment. Also under this grant, funding was used to establish a dental hygienist position to work in areas of need under a new remote practice protocol.

c. Plan for the Coming Year
DDH will continue to track dentists and dental hygienists who have an obligation to serve in an area of need. DDH will conduct a manpower analysis as required by regulation. That analysis is due to be completed in 2011. Efforts are being made to continue to find other sources of funds for these programs.

State Performance Measure 7: *The proportion of children (0-21 years) who receive genetic testing.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		32	35	38	39
Annual Indicator	26.4	29.9	34.5	34.0	30.6
Numerator	2438	3431	3569	3674	3194
Denominator	9234	11493	10330	10796	10438
Data Source				Virginia Genetics Program	Virginia Genetics Program
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	41	42	42	

Notes - 2009
Data for the numerator are from three contracted genetic centers and include all children seen under age 21 (both new and follow up)

Data from denominator are from birth defects cases mandated to be reported through Virginia Congenital Anomalies and Reporting System. These are only children (up to age 2) hospitalized with certain defects as mandated in the Code of Virginia. These data are provisional as the measurement parameters are being refined.

Notes - 2008
Data for the numerator are from three contracted genetic centers and include all children seen under age 21 (both new and follow up)

Data from denominator are from birth defects cases mandated to be reported through Virginia Congenital Anomalies and Reporting System. These are only children (up to age 2) hospitalized with certain defects as mandated in the Code of Virginia. These data are provisional as the measurement parameters are being refined.

Notes - 2007
Data for the numerator are from three contracted genetic centers and include all children seen under age 21 (both new and follow up)

Data from denominator are from birth defects cases mandated to be reported through Virginia Congenital Anomalies and Reporting System. These are only children (up to age 2) hospitalized with certain defects as mandated in the Code of Virginia.
These data are provisional as the measurement parameters are being refined.

a. Last Year's Accomplishments
The Genetics and Newborn Screening unit within DCAH continued to contract with three genetic/metabolic treatment centers to assure that genetic services were available to all uninsured and under-insured children and their families in the state. Contractual relationships were maintained with Eastern Virginia Medical School, Children's Specialty Group; University of Virginia, Department of Genetics; and Virginia Commonwealth University, Department of Human Genetics. DCAH also contracted with the Genetics and IVF Institute for genetic services for prenatal patients in the Northern Virginia area.

The three genetic/metabolic centers continued to submit quarterly activity reports, which documented numbers of patients, number of referrals to and from each center, telephone contacts, educational activities, and insurance coverage. The number of VaCARES hospitals reporting online was maintained at 98-99 percent. Monthly reports of hospital-reported patients and an annual progress report were disseminated. This individualized feedback to each hospital continued to generate positive results from the hospitals in the form of the expressed desire to continue to improve individual hospital performance. The contracted genetic counselor continued to work in Genetics and Newborn Screening and continued many of the activities related to data quality and improvement. Funding for this position was from a five-year CDC cooperative agreement, budget period March 2, 2005 to February 28, 2010. The family genetic history tool, which was completed in 2008, continued to be disseminated online. The purpose of the tool is to help families identify risks for genetic inherited disorders.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain contracts with genetic centers to assure genetic services are available to all children and families in Virginia.				X
2. Mail letters to parents identified through the Virginia Congenital Anomalies and Reporting System to increase knowledge regarding available resources.	X			
3. Support the Virginia Genetics Advisory Committee and its activities.				X
4. Redesign and maintain the Virginia Infant Tracking and Infant Screening web-based data system to provide better surveillance of genetic screening and results.				X
5. Strengthen referral systems to ensure that all children and families are referred for genetic testing and counseling when appropriate.				X

6. Disseminate family genetic history tool to help families identify their risk for genetic inherited disorders.		X		
7. Review and make recommendations regarding proposed legislation or policies addressing genetic testing.				X
8.				
9.				
10.				

b. Current Activities
In FY 2010, Genetics and Newborn Screening continues to contract with three genetic/metabolic centers to assure availability of genetic services for children and families statewide.

DCAH supports the Virginia Genetics Advisory Committee (VaGAC), which is chaired by a medical geneticist. This group provides advice on planning, implementing, and evaluating services including newborn bloodspot screening and birth defects prevention. VaGAC has several subgroups, including the State Genetics Plan and Public Health Subcommittee, Newborn Screening Subcommittee, Birth Defects Prevention Subcommittee, and the VDH Contractors Ad Hoc Work Group.

VaCARES parent contact activities continue. Letters are sent to families of children diagnosed with certain disorders; the letters include a fact sheet on the child's specific disorder and information on available genetic, family support, and other community based resources.

DCAH continues work with the Office of Information Management on enhancing the Virginia Infant Screening and Infant Tracking System (VISITS). VISITS II, released statewide on April 12, 2010, includes a new linkage to the electronic birth certificate. This database tracks infants and children diagnosed with certain birth defects and genetic and heritable disorders.

The contracted Genetic Counselor position was no longer funded at the end of a five-year CDC cooperative agreement.

c. Plan for the Coming Year
In FY 2011, Genetics and Newborn Screening will continue contracting with the following genetic/metabolic treatment centers to assure that genetic services are available to all uninsured and under insured children and their families in the state: Eastern Virginia Medical School, Children's Specialty Group; University of Virginia, Department of Genetics; and Virginia Commonwealth University, Department of Human Genetics. DCAH will also continue its contractual relationship with the Genetics and IVF Institute for genetic services for prenatal patients in the Northern Virginia area.

VaGAC will continue its work on coordinating access to clinical genetic services across the Commonwealth, assuring the provision of genetic awareness, and quality services and education for consumers and providers.

VISITS II will continue to undergo enhancements, including programming functions that will include (1) automatic referrals of children with certain birth defects to Care Connection for Children and (2) referral of children at risk for developmental disabilities, including children with hearing loss, to Part-C Early Intervention through an interagency data exchange processes. A matching process will be implemented to receive feedback on children enrolled in Part C-Early Intervention services who were referred from VISITS II. These processes will further program objectives to assure that all children and families with identified genetic disorders will have access to case management services and assistance with obtaining needed services and coverage.

The contracted Genetic Counselor position was no longer funded at the end of a five-year CDC cooperative agreement. Most of the Genetic Counselor's responsibilities have been transferred

to the Genetics and Newborn Screening Director, VaCARES support technician, and DCAH System Analyst. Birth defects prevention responsibilities were assigned to the Division of Women's and Infants' Health under the perinatal nurse consultant's supervision.

State Performance Measure 8: *The percent of women reporting substance use during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		6.6	6.3	6	5.7
Annual Indicator	6.6	6.5	6.3	6.3	6.3
Numerator	7412	7380	7314	7143	6600
Denominator	111583	113392	115779	114015	104135
Data Source				VA birth fetal itop data	VA provisional birth data
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5.4	5.3	5.2	5.2	

Notes - 2009
2009pregnancy data is not yet available. Entry is an estimate based provisional birth data.

Notes - 2008
Data from 2008 birth, fetal death, and intentional termination of pregnancy certificates.

Notes - 2007
Data from 2007 birth, fetal death, and intentional termination of pregnancy certificates.

a. Last Year's Accomplishments
The Virginia Council on Folic Acid and the Fetal Alcohol Spectrum Disorder Task Force was combined into a Birth Defects Prevention Committee, which is a subcommittee of the Virginia Genetics Advisory Board.

RPCs monitor substance use trends through FIMR. Trends are discussed during Community Action Team meetings with key stakeholders planning and implementing programs and services unique to the needs of regional citizens. Project Link representatives provide consultation to all the RPCs within Virginia. Southwest region, in partnership with Project Link, has placed a billboard message on a major road in Southwest Virginia. The message reminds people that substance use of any kind affects both mother and fetus. This area has a higher percentage of substance use within the state. This region also expanded the substance use task force with a plan to examine existing screening policies and coordinate efforts to implement inpatient prenatal drug screening. Eastern Virginia region developed a plan to increase community awareness of programs and services available to pregnant women to include services for women using substances.

OFHS participated in the Substance Abuse Services Council to make recommendations to the Governor, the General Assembly, and the Virginia Department of Behavioral Health and Developmental Services on the coordination of public and private efforts to control substance abuse in Virginia. Recommendations included a call to appropriate funds for a universal

statewide screening protocol for risks related to substance abuse, mental illness, and domestic violence, and to support increased access to treatment for pregnant women and women with dependent children through targeted case management.

DWIH staff continued to serve on the interagency Substance Exposed Newborns Workgroup and provided consultation on development of the Virginia Department of Behavioral Health and Developmental Services' web page on screening for substance use in health care settings.

In FY 2009, VHSI staff screened for substance use during pregnancy and the interconception period and provided education. VHSI continued using the "I Am Concerned: A Brief Intervention for the Primary Prenatal Care Setting" tool to screen and identify women who use substances. Staff continued to work with the Community Service Boards, Project LINK, and local Medicaid providers to assure that women are assessed, diagnosed, and treated for substance use.

VHSI and Resource Mother programs continue to use the Florida State University Curriculum training, "Partnering for a Healthy Baby", which includes substance use education and promotion of smoking cessation. Both programs refer to the QuitLine.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Begin to analyze data reporting substance use through PRAMS and develop strategies for reducing use.				X
2. Continue to promote concerns related to substance use and smoking cessation from the RPCs, VHSI, health district prenatal clinics and other VDH sponsored programs.		X	X	
3. Collaborate with DMAS to update and improve screening of substance use during pregnancy for women in BabyCare.		X		X
4. Participate in an interagency task force to identify a methodology to train providers in screening and referral of substance users.		X		X
5. Review and make recommendations regarding proposed legislation or policies addressing substance use treatment services for women.				X
6. RPCs will monitor substance use trends in individual regions of Virginia through FIMR.		X		X
7.				
8.				
9.				
10.				

b. Current Activities

The percent of women self-reporting substance abuse is decreasing and reflects a statistically significant downward trend in substance use from 7.3% in 2003 to 6.3% in 2008. Since birth certificate information is self-reported, there may be an under reported incidence of substance use. PRAMS surveys are confidential and may indicate a more valid percentage of alcohol and smoking. In 2007, PRAMS data revealed that 7.8% of women reported drinking alcohol during pregnancy.

The interagency Substance Exposed Newborn Workgroup is developing two guideline documents to assist providers screening for substance use during pregnancy. One document will target health care providers and the other will target community health workers and child welfare

workers.

DWIH participated in interagency training opportunities to enhance provider knowledge of screening and referral of substance abusers.

The Home Visiting Consortium, a collaboration of 10 state home visiting programs, has identified screening for substance use (including tobacco) as part of its 12 core training modules. The development of the training module is in process.

RPCs monitor substance use trends through FIMR. Trends are discussed during Community Action Team meetings with key stakeholders planning and implementing programs and services unique to the needs of regional citizens.

c. Plan for the Coming Year

PRAMS data will be analyzed and shared with appropriate partners to develop strategies for reducing substance use. Partners include:

o Birth Defects Prevention Committee
o RPC's
o Virginia Healthy Start Initiative
o Resource Mothers
o health district prenatal clinics
o other VDH sponsored programs

VDH sponsored programs will continue to investigate concerns related to substance use and smoking cessation and propose strategies to implement with appropriate partners. The partner organizations will have knowledge and capacity to impact the incidence of substance use and may have the capacity to provide education to the public concerning substance use in pregnancy issues and potential outcomes.

DWIH will collaborate with DMAS to update and improve screening of substance use during pregnancy for women in BabyCare and other Medicaid programs.

RPCs will monitor substance use trends in individual regions of Virginia through FIMR.

The Home Visiting Consortium will offer, as part of core training for early childhood home visitor, online modules on substance use and another on the use of screening tools, as well as training sessions including practicing application to case studies. Resource Mothers and VHSI are members of the Consortium and will participate.

Previously, a contractor managed the Virginia Sickle Cell Awareness program and the Comprehensive Sickle Cell Services Program. The role has been integrated into a state full-time position to address birth defects prevention. One of the job duties of the Preconception Health Coordinator will include addressing prenatal drug exposure.

State Performance Measure 9: *The percent of women with an ongoing source of primary care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		90	91	92	93

Annual Indicator	87.3	88.6	85.8	86.4	85.8
Numerator	2565851	2626848	2581899	2641530	2635237
Denominator	2937536	2965666	3010379	3057506	3073061
Data Source				BRFSS	BRFSS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	94	94	94	94	

Notes - 2009
2009 BRFSS data.

Notes - 2008
2008 BRFSS data.

Notes - 2007
2007 BRFSS data.

a. Last Year's Accomplishments
The Code of Virginia 32.1 -- 11.5 was amended in 2006 permitting the Board of Health to approve pilot programs to improve access to obstetrical and pediatric care by establishing birth centers. Funds from both the 2007 and 2008 General Assembly were allocated to VDH to support this effort. OFHS staff assisted VDH Community Health Services with overseeing contracts and provided technical assistance to the two pilot projects. One center is scheduled to open May 2010. The other center is planned to open later in 2010.

The VHSI staff connected women to sources of health care, assisted with application to insurance carriers, and helped ste up appointments. VHSI conducted an interconception care learning community project at the Norfolk site in FY 2009 that included connecting women to postpartum health services, development of a reproductive life plan, and assistance with application to the PlanFirst Medicaid program.

VDH supported health districts in providing obstetrical and interconception women's health by providing financial, technical, and educational opportunities.

OFHS staff provided numerous presentations throughout the state to medical professionals. Topics presented were interconception healthcare, infant mortality issues, breast and cervical cancer advances and issues, family planning advances, and perinatal depression.

DWIH received a grant from the Centers for Disease Control and Prevention (CDC) to establish the WISEWOMAN Program within the existing Breast and Cervical Cancer Early Detection Program. This program, currently being implemented, will include preventive health services to determine heart disease and stroke risk by assisting women to improve their diet, increase physical activity, live tobacco free, and adopt healthier lifestyles.

DWIH completed the Perinatal Health Care Provider Follow-Up Survey in 2009. There were 1,498 responses from healthcare providers with an active practice in women's and/or pediatric health. The data demonstrated that there is readiness among providers to move from "buy in" regarding the importance of detection towards strategies that help address barriers in assessment, referral, and treatment.

The Comprehensive Sickle Cell Services program piloted a transition program for youths with Sickle Cell disease into adult services. A detailed series of assessment tools were developed and revised with input from families and staff.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide case management services through Resource Mothers and the VHSI.		X		
2. Strengthen connections with local health care providers through program outreach activities.		X		X
3. Improve the referral systems of local health departments and community agencies.			X	X
4. Review and make recommendations regarding proposed legislation or policies addressing women's access to care.				X
5. Continue interconception care activities to connect women to postpartum health services and development of reproductive life plan.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The baseline of 86.8% was established in 2004 using Behavioral Risk Factors Surveillance System (BRFSS) data. Currently, BRFSS data show that 86.4% of women report an ongoing source of primary care. Of the clients that are served in the Title X (Family Planning) clinics, 78.4% report having no principle health insurance covering primary medical care in 2009. This data represents a 1.3% decrease from 2008 to 2009.

VDH will continue to support health districts that provide obstetrical and interconception women's health by providing financial, technical, and educational opportunities. Access to primary care will be monitored.

The Sickle Cell Transition Intervention Program (TIP) has been implemented to provide guidance to sickle cell clients making transition from pediatric to adult care. Information on developing a reproductive health plan, sexuality, and contraception is included.

The WISEWOMAN Program has been implemented in ten sites. Of the 500 women screened, 80% have been referred for additional diagnostic testing. WISEWOMAN provider site staff have been educated to assist women improve their diet, increase physical activity, live tobacco free, and adopt healthier lifestyles.

Resource Mothers and VHSI, through the Home Visiting Consortium, have promoted the concepts of centralized referral, use of the 211 phone line, and follow-up on referrals that are made. Referrals and follow-up are tracked in the RMP and VHSI database.

c. Plan for the Coming Year

Perinatal case management will continue through the Resource Mothers Program and VHSI. The Home Visiting Consortium will develop and offer a module on making effective referrals. RMP and VHSI are partners in the Consortium and will continue participation in activities.

As the state Medicaid agency makes major changes to the BabyCare data collection system, the Home Visiting Consortium will participate in planning activities so that information needed for Title V reports is included.

VDH will continue to support health districts that provide obstetrical and interconception women's health by providing financial, technical, and educational opportunities. Access to care will be monitored.

DWIH is developing a plan to respond to the Perinatal Health Care Provider Follow-Up Survey regarding screening and treatment of post partum depression. One of the most beneficial courses of action may be to consider the ways in which various specializations can each contribute unique perspectives and strengths to the assessment, referral, and treatment of perinatal depression and then facilitate education and support. An advocacy group has started Postpartum Support Virginia. DWIH is exploring ways to partner with this group to increase awareness of the public regarding perinatal depression and to increase the screening for perinatal depression by providers.

VHSI plans to replicate the interconception care learning community project in its two other sites in FY 2010.

The Sickle Cell Transition Intervention Program (TIP) will be evaluated for effectiveness and usefulness to the participants. All four comprehensive sickle cell centers will participate by reporting data from the assessment forms, which will be analyzed through a partnership with the Virginia Commonwealth University Adult Sickle Cell Services.

In 2008, PlanFirst began providing services for routine and periodic family planning office visits. Available for men and women, the visit includes annual physical exams, cervical cancer screening for women, testing and laboratory services related to sexually transmitted infections, and family planning. Education and counseling is conducted in the areas of family planning options and decisions. DWIH conducted a brief survey of the barriers to enrolling women on this plan and has shared results of that survey with Community Health Services.

E. Health Status Indicators

Introduction

Over the past five years the leadership in the Office of Family health Services has made a strong commitment to improving MCH surveillance capacity through the use of Title V, State Systems Development Initiative (SSDI), and other funding such as the CDC Assessment Initiative, the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Virginia Youth survey (YRBS). With the development of an OFHS Data Mart and the agency Data Warehouse, all staff now have easier access to vital records data, hospital discharge data and other health status indicators that are updated on a regular and timely basis. This provides data that are used to identify trends, target program initiatives and evaluate efforts to determine the most effective use of resources. Health Status Indicators #01A, 01B, 02A, 07A and 07B provide a basis for developing plans and resource allocations for such initiatives as Healthy Start, Resource Mothers, and the Regional Perinatal Councils. Health Status Inidicators #03A, 03B, 04A, 04B, and 04C and child death data are used to target and evaluate injury prevention efforts. Indicators #05A and 05B are primarily monitored by the Office of Epidemiology and the Family Planning program. The demographic data are used by all divisions for long range planning and the WIC, Medicaid, SCHIP data are used to inform outreach efforts.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	8.1	8.2	8.5	8.3	8.3
Numerator	8452	8748	9186	8868	8396
Denominator	104488	106474	108417	106578	101295
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 provisional birth certificate data.

Notes - 2008
2008 birth certificate data.

Notes - 2007
Data from birth certificates, 2007.

An attachment is included in this section.

Narrative:
In 2008, 8.3 percent of all live births were low birth weight infants. Since 1999 there has been a significant increasing trend in low birth weight births in all births. The racial/ethnic disparity in low birth weight infants remained in 2008. Of all black non-Hispanic infants, 12.8% were low birth weight. For white non-Hispanic infants, 7.1% were low birth weight. Hispanic infants of any race continued to have the lowest percent of low birth weight infants (6.5%).

In the fall of 2008, the State Health Commissioner convened a work group of medical and health professionals and community and civic leaders to adress the infant mortality. Prematurity and low birth weight are major contributors to infant mortality, The Infant Mortality Working Group during the past year has developed ways to share information with pregnant women, their families and others int he community. Their emphasis is on helping expectant moms with birth preparations that include information on prenatal care, nutrition, controlling weight gain, not smoking and carrying a baby to full term whenever possible. One innovative program that has been implemented is text4baby. The program provides three free text messages each week to pregnant women and new mothers who sign up for the service by texting BABY to 511411 (or BEBE for Spanish). The messages are timed to the due date or baby's date of birth and cover such topics that include birth defects prevention, immunization, nutrition, mental health, oral health and safe sleep.

In 2006 Virginia was awarded a CDC Pregnancy Risk Assessment and Monitoring System (PRAMS) grant. Virginia has received the first two years of PRAMS data. The survey provides data regarding pregnancy experience and outcomes that will be used to target populations and future interventions that address issues relating to low birth weight such as smoking, nutrition, pre pregnancy weight, pregnancy weight gain, preconceptual health, birth spacing and pregnancy intentions.

Virginia continues to provide approximately $3.5 million of Title V funding to the 35 health districts. In FY 2010, thirty of the thirty-five districts used Title V funds to support prenatal care, while nine districts used the funds to support breastfeeding initiatives. This amounts to approximately sixty percent of the total Title V funds provided to the district health departments. In addition, through other funding, the Resource Mothers program and the Virginia Healthy Start Initiative target populations that are at a high risk for low birth weight infants.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	6.3	6.5	6.6	6.5	6.5
Numerator	6346	6640	6938	6715	6302
Denominator	100767	102744	104489	102776	97585
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 provisional birth certificate data.

Notes - 2008
2008 birth certificate data.

Notes - 2007
Data from birth certificates, 2007.

An attachment is included in this section.

Narrative:
Of all live singleton births in 2008, 6.5 percent of the infants weighed less than 2,500 grams. The racial/ethnic disparities remained in 2008. The percent of Black non-Hispanic LBW singleton births were twice that of white non-Hispanic LBW singleton births (10.7 vs. 5.3 percent). The percent of Hispanic LBW singleton births was 5.4 percent. Analysis of the data shows that since 1999 there is a significantly increasing trend in LBW among singletons.

In 2006, Virginia was awarded a CDC Pregnancy Risk Assessment and Monitoring System (PRAMS) grant. Virginia currently has two years of PRAMS data. The survey provides data regarding pregnancy experience and outcomes that will be used to target populations and future interventions that address issues relating to low birth weight such as smoking, nutrition, pre pregnancy weight, pregnancy weight gain, preconceptual health and birth spacing.

Each year Virginia provides approximately $3.5 million of Title V funding to the thirty-five health districts. In FY 2010, thirty of the thirty-five health districts will use Title V funds to support prenatal care, while nine districts will use the funds to support their breastfeeding initiatives. The Title V funding for prenatal care and breastfeeding account for approximately sixty percent of the total Title V funds provided to the district health departments. In addition through other funding, the Resource Mothers program and the Healthy Start program target populations that are at a high risk for low birth weight infants.

In the fall of 2008, the State Health Commissioner convened a work group of medical and health professionals and community and civic leaders to adress the infant mortality. Prematurity and low birth weight are major contributors to infant mortality, The Infant Mortality Working Group during the past year has developed ways to share information with pregnant women, their families and others int he community. Their emphasis is on helping expectant moms with birth preparations

that include information on prenatal care, nutrition, controlling weight gain, not smoking and carrying a baby to full term whenever possible. One innovative program that has been implemented is text4baby. The program provides three free text messages each week to pregnant women and new mothers who sign up for the service by texting BABY to 511411 (or BEBE for Spanish). The messages are timed to the due date or baby's date of birth and cover such topics that include birth defects prevention, immunization, nutrition, mental health, oral health and safe sleep.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.6	1.6	1.6	1.6	1.6
Numerator	1607	1717	1741	1653	1614
Denominator	102680	104577	108417	106578	101295
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 provisional birth certificate data.

Notes - 2008
2008 birth certificate data.

Notes - 2007
2007 birth certificate data.

An attachment is included in this section.

Narrative:
In 2008, 1.6 percent of all live births were very low birth weight (VLBW) infants. Looking at the data from 1999 to 2008, it is unclear if there is any significant trend in the overall percent of VLBW infants. The racial dispartiy continued in 2008 with 2.6% of black non-Hispanic births resulting in a VLBW infant and 1.3% of white non-Hispanic births being VLBW. Hispanics of any race had the lowest percent of VLBW infants at 1.1 percent.

In 2006, Virginia was awarded a CDC Pregnancy Risk Assessment and Monitoring System (PRAMS) grant. Virginia currently has two years of PRAMS data. The survey provides data regarding pregnancy experience and outcomes that will be used to target populations and future interventions that address issues relating to low birth weight such as smoking, nutrition, pre pregnancy weight, pregnancy weight gain, preconceptual health and birth spacing.

Each year Virginia provides approximately $3.5 million of Title V funding to the thirty-five health districts. In FY 2010, thirty of the thirty-five health districts will use Title V funds to support prenatal care, while nine districts will use the funds to support their breastfeeding initiatives. The Title V funding for prenatal care and breastfeeding account for approximately sixty percent of the total Title V funds provided to the district health departments. In addition through other funding,

the Resource Mothers program and the Healthy Start program target populations that are at a high risk for low birth weight infants.

In the fall of 2008, the State Health Commissioner convened a work group of medical and health professionals and community and civic leaders to adress the infant mortality. Prematurity and low birth weight are major contributors to infant mortality, The Infant Mortality Working Group during the past year has developed ways to share information with pregnant women, their families and others int he community. Their emphasis is on helping expectant moms with birth preparations that include information on prenatal care, nutrition, controlling weight gain, not smoking and carrying a baby to full term whenever possible. One innovative program that has been implemented is text4baby. The program provides three free text messages each week to pregnant women and new mothers who sign up for the service by texting BABY to 511411 (or BEBE for Spanish). The messages are timed to the due date or baby's date of birth and cover such topics that include birth defects prevention, immunization, nutrition, mental health, oral health and safe sleep.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.2	1.3	1.2	1.2	1.2
Numerator	1189	1317	1286	1268	1205
Denominator	99403	102744	104489	102776	97585
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 provisional birth certificate data.

Notes - 2008
2008 birth certificate data.

Notes - 2007
2007 birth certificate data.

An attachment is included in this section.

Narrative:
In 2008, 1.2 percent of all live singleton births were very low birth weight (VLBW) infants. The racial disparity continues with 2.2 percent of black non-Hispanic live births resulting in a VLBW infant and 1.0 percent of white non-Hispanic births being VLBW. Hispanic, any race had a percent very similar to the white non-Hispanic group (.9 vs 1.0 percent).

In 2006, Virginia was awarded a CDC Pregnancy Risk Assessment and Monitoring System (PRAMS) grant. Virginia currently has two years of PRAMS data. The survey provides data

regarding pregnancy experience and outcomes that will be used to target populations and future interventions that address issues relating to low birth weight such as smoking, nutrition, pre pregnancy weight, pregnancy weight gain, preconceptual health and birth spacing.

Each year Virginia provides approximately $3.5 million of Title V funding to the thirty-five health districts. In FY 2010, thirty of the thirty-five health districts will use Title V funds to support prenatal care, while nine districts will use the funds to support their breastfeeding initiatives. The Title V funding for prenatal care and breastfeeding account for approximately sixty percent of the total Title V funds provided to the district health departments. In addition through other funding, the Resource Mothers program and the Healthy Start program target populations that are at a high risk for low birth weight infants.

In the fall of 2008, the State Health Commissioner convened a work group of medical and health professionals and community and civic leaders to adress the infant mortality. Prematurity and low birth weight are major contributors to infant mortality, The Infant Mortality Working Group during the past year has developed ways to share information with pregnant women, their families and others int he community. Their emphasis is on helping expectant moms with birth preparations that include information on prenatal care, nutrition, controlling weight gain, not smoking and carrying a baby to full term whenever possible. One innovative program that has been implemented is text4baby. The program provides three free text messages each week to pregnant women and new mothers who sign up for the service by texting BABY to 511411 (or BEBE for Spanish). The messages are timed to the due date or baby's date of birth and cover such topics that include birth defects prevention, immunization, nutrition, mental health, oral health and safe sleep.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.0	6.0	7.3	5.2	6.1
Numerator	105	89	110	79	
Denominator	1508838	1490293	1508669	1510607	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data not yet available. Entry is an estimate based on trend.

Notes - 2008
Data from death certificates and NCHS population estimates, 2008.

Notes - 2007
Data from death certificates and NCHS population estimates, 2007

An attachment is included in this section.

Narrative:
In 2008 there were 5.2 unintentional injury deaths per 100,000 children aged 14 years and younger. From 1999 to 2008 there is no significant decreasing or increasing trend in the unintentional injury deaths in this population. In 2008, black non-Hispanic children 14 years and younger had the highest rate of death from unintentional injuries (6.4 deaths per 100,000), while white non-Hispanic rate was 5.5 per 100,000 and the Hispanic rate was the lowest at 1.9 per 100,000 children under age 14 years.

VDH's Division of Injury and Violence Prevention (DIVP) promotes prevention of injuries to children through public information, training, community education and events, and support for community coalitions. The unintentional injury prevention program focuses on the prevention of the leading causes of fatal and non-fatal unintentional injures in Virginia by examining injury patterns and by identifying groups at high risk and potentially modifiable factors. The program focuses available resources on the prevention of unintentional injuries determined to be the leading causes based on available Virginia injury data. Resources are also focused on those causes that have an enormous impact on audiences that can be effectively targeted with information and countermeasures that will result in the desired behavior change. The program utilizes prevention strategies and related activities at both the state and local levels to support the accomplishment of goals in the areas of child passenger safety, traumatic brain injury, fire and burn prevention and general injury prevention outreach, education and policy. These strategies include raising awareness of the scope of the injury problem through sharing of data, information and resources, presentations, trainings and exhibits, and collaborative projects; increasing the number of state and local agencies, organizations and groups committed to and working on injury prevention through consultation and technical assistance, leadership of a state injury planning group, coordination of local prevention projects and dissemination of proven safety devices and partnerships; and policy development.

The Division's child passenger safety program promotes proper safety seat restraint use from birth until a child transitions to the vehicle's safety belt system. This program provides consultation to the general public, coordinates statewide information campaigns and is developing resources and initiatives to enable health care providers to ensure parents and caregivers safely transport newborns. The program also coordinates a statewide child passenger safety program that provides education and free child safety seats and booster seats to families that could not otherwise afford them and supports staffed local sites where the public can learn how to properly install their safety seats.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.3	1.7	2.3	1.3	1.6
Numerator	35	26	34	20	
Denominator	1508838	1490293	1508669	1510607	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data not yet available. Entry is an estimate based on trend. Relevant changes in Virginia law: July 1, 2010 : All children between their 8th and 18th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine

Notes - 2008
2008 death certificate data and NCHS population estimates.

Notes - 2007
2007 death certificate data and NCHS population estimates.
Relevant changes in Virginia Law:
July 1, 2002:
--All children under age six must be properly restrained in a child safety seat or booster seat. Violations will result in a $50 fine.
--All children between their 6th and 16th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.
July 1, 2007:
--Child restraint devices are required for children through the age of seven (until 8th birthday). Violations will result in a $50 fine.
--Rear-facing child restraint devices must be placed in the back seat of a vehicle. In the event the vehicle does not have a back seat, the child restraint device may be placed in the front passenger seat only if the vehicle is either not equipped with a passenger side airbag or the passenger side airbag has been deactivated.Violations will result in a $50 fine.
--Children can no longer ride unrestrained in the rear cargo area of vehicles. Violations will result in a $50 fine.
--All children between their 8th and 16th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.

An attachment is included in this section.

Narrative:
Since 1999 there has been no significant change in the rate of death from motor vehicle crashes among children aged 14 years and younger. In 2008 the rate was 1.3 per 100,000 children in this age range; in 1999 the rate was 2.6. The death rate for Hispanic children aged 14 years and younger due to motor vehicle crashes is the lowest among all population groups (.06 per 100,000).

VDH's Division of Injury and Violence Prevention (DIVP) promotes the prevention of injuries to children through public information, training, community education and events, and support for community coalitions. The unintentional injury prevention program focuses on the prevention of the leading causes of fatal and non-fatal unintentional injures in Virginia by examining injury patterns and by identifying groups at high risk and potentially modifiable factors. The program focuses available resources on the prevention of unintentional injuries determined to be the leading causes based on available Virginia injury data. Resources are also focused on those causes that have an enormous impact on audiences that can be effectively targeted with information and countermeasures that will result in the desired behavior change. The program utilizes prevention strategies and related activities at both the state and local levels to support the accomplishment of goals in the areas of child passenger safety, traumatic brain injury, fire and burn prevention and general injury prevention outreach, education and policy. These strategies include raising awareness of the scope of the injury problem through sharing of data, information and resources, presentations, trainings and exhibits, and collaborative projects; increasing the number of state and local agencies, organizations and groups committed to and working on injury prevention through consultation and technical assistance, leadership of a state injury planning

group, coordination of local prevention projects and dissemination of proven safety devices and partnerships; and policy development.

The Division's child passenger safety program promotes proper safety seat restraint use from birth until a child transitions to the vehicle's safety belt system. This program provides consultation to the general public, coordinates statewide information campaigns and is developing resources and initiatives to enable health care providers to ensure parents and caregivers safely transport newborns. The program also coordinates a statewide child passenger safety program that provides education and free child safety seats and booster seats to families that could not otherwise afford them and supports staffed local sites where the public can learn how to properly install their safety seats. Additional federal highway safety funding resulting from improvements in the child passenger safety law in 2007, has enabled the division to increase media efforts around child passenger safety over the past two years.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	22.3	25.4	24.8	21.7	23.6
Numerator	239	270	267	235	
Denominator	1071442	1063662	1078644	1081069	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data not yet available. Entry is an estimate based on trend.

Notes - 2008
2008 death certificate data and NCHS population estimates.

Notes - 2007
2007 death certificate data and NCHS population estimates.

An attachment is included in this section.

Narrative:
Since 1999, there has been no statistically significant change in the death rate from motor vehicle crashes among youth aged 15 through 24 in Virginia. In 1999 the rate was 20.5 and in 2008 the rate was 21.7 per 100,000 youth in this aged group. In 2008 the death rate for black non-Hispanic was 17.7 and for white non-Hispanic and Hispanic the death rate was 23.0 and 27.2 respectively. The Division of Injury and Violence Prevention currently does not have projects or programs that directly impact this age group. However, the division does provide data and best practice and promising practice information to communities and organizations when requested. Division staff also participates on state level committees that are beginning to look more in depth at this age group and potential programs that may address this issue. Of the Virginia high school students responding to the 2009 Virginia Youth Survey, 11.7% said that they never or rarely wear a seat

belt when riding in a car. In addition, 24.7% of the respondents indicated that they had ridden with a driver who had been drinking in the past 30 days. These responses show how the risk behavior of youth has a potential impact on the unintentional injuries and deaths from motor vehicle crashes.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	252.8	186.5	190.6	176.0	184.5
Numerator	3815	2780	2875	2659	
Denominator	1508838	1490293	1508669	1510607	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data not yet available. Entry is an estimate based on trend. Relevant changes in Virginia law: July 1, 2010: All children between their 8th and 18th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.

Notes - 2008
Data from Virginia hospitalization discharge data and NCHS population estimates, 2008.

Notes - 2007
Data from Virginia hospitalization discharge data and NCHS population estimates, 2007.

An attachment is included in this section.

Narrative:
Since 1999 the rate of nonfatal injuries in children aged 14 years and younger has significantly decreased from 225.7 per 100,000 children aged 14 years and younger to 176 in 2008. A change in Virginia's child restraint law in 2007 has contributed to the decrease in nonfatal injuries and motor vehicle deaths. In 2007 the age requirement for children to be secured in an approved safety seat while riding in a vehicle increased from five to eight years old.

VDH's Division of Injury and Violence Prevention (DIVP) promotes prevention of injuries to childrenthrough public information, training, community education and events, and support for community coalitions. The unintentional injury prevention program focuses on the prevention of the leading causes of fatal and non-fatal unintentional injures in Virginia by examining injury patterns and by identifying groups at high risk and potentially modifiable factors. The program focuses available resources on the prevention of unintentional injuries determined to be the leading causes based on available Virginia injury data. Resources are also focused on those causes that have an enormous impact on audiences that can be effectively targeted with information and countermeasures that will result in the desired behavior change. The program utilizes prevention strategies and related activities at both the state and local levels to support the accomplishment of goals in the areas of child passenger safety, traumatic brain injury, fire and

burn prevention and general injury prevention outreach, education and policy. These strategies include raising awareness of the scope of the injury problem through sharing of data, information and resources, presentations, trainings and exhibits, and collaborative projects; increasing the number of state and local agencies, organizations and groups committed to and working on injury prevention through consultation and technical assistance, leadership of a state injury planning group, coordination of local prevention projects and dissemination of proven safety devices and partnerships; and policy development.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	14.4	15.2	13.5	10.8	10.1
Numerator	218	226	203	163	
Denominator	1508838	1490293	1508669	1510607	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data not yet available. Entry is an estimate based on trend.

Notes - 2008
Data from Virginia hospitalization discharge data and NCHS population estimates, 2008.

Notes - 2007
Data from Virginia hospitalization discharge data and NCHS population estimates, 2007.
Relevant changes in Virginia Law:
July 1, 2002:
--All children under age six must be properly restrained in a child safety seat or booster seat. Violations will result in a $50 fine.
--All children between their 6th and 16th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.
July 1, 2007:
--Child restraint devices are required for children through the age of seven (until 8th birthday). Violations will result in a $50 fine.
--Rear-facing child restraint devices must be placed in the back seat of a vehicle. In the event the vehicle does not have a back seat, the child restraint device may be placed in the front passenger seat only if the vehicle is either not equipped with a passenger side airbag or the passenger side airbag has been deactivated.Violations will result in a $50 fine.
--Children can no longer ride unrestrained in the rear cargo area of vehicles. Violations will result in a $50 fine.
--All children between their 8th and 16th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.

An attachment is included in this section.

Narrative:
Since 1999 the rate of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger has significantly decreased. In 2008 the rate was 10.8 per 100,000 children in this age range. Black non-Hispanic children had the highest rate of nonfatal injuries (15.8) and Hispanic children had the lowest rate (4.4).

VDH's Division of Injury and Violence Prevention (DIVP) promotes prevention of injury to children through public information, training, community education and events, and support for community coalitions. The unintentional injury programs focus on the prevention of the leading causes of fatal and non-fatal unintentional injuries including child passenger safety. The division distributes materials through its resource center, provides program consultation and technical assistance, and serves as the consumer product safety liaison for Virginia. Many childhood injury prevention services are provided through broad-based coalitions.

The Division's child passenger safety program promotes proper safety seat restraint use from birth until a child transitions to the vehicle's safety belt system. This program provides consultation to the general public, coordinates statewide information campaigns and is developing resources and initiatives to enable health care providers to ensure parents and caregivers safely transport newborns. The program also coordinates a statewide child passenger safety program that provides education and free child safety seats and booster seats to families that could not otherwise afford them and supports staffed local sites where the public can learn how to properly install their safety seats. Additional federal highway safety funding resulting from improvements in the child passenger safety law in 2007, has enabled the division to increase media efforts around child passenger safety over the past two years.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	101.1	106.1	102.6	92.4	88.8
Numerator	1083	1129	1107	999	
Denominator	1071442	1063662	1078644	1081069	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data not yet available. Entry is an estimate based on trend.

Notes - 2008
Data from Virginia hospitalization discharge data and NCHS population estimates, 2008.

Notes - 2007
Data from Virginia hospitalization discharge data and NCHS population estimates, 2007.

An attachment is included in this section.

Narrative:
Since 1999, there has been a significant decreasing trend in the rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24. In 1999 the rate was 127/100,000 and in 2008 the rate had decreased to 92.4/100,000 in this age group. The Division of Injury and Violence Prevention currently does not have projects or programs that directly impact this age group. However, the division does provide data and best practice and promising practice information to communities and organizations when requested. Division staff also participates on state level committees that are beginning to look more in depth at this age group and potential programs that may address this issue. Of the Virginia high school students responding to the 2009 Virginia Youth Survey, 11.7% said that they never or rarely wear a seat belt when riding in a car. In addition, 24.7% of the respondents indicated that they had ridden with a driver who had been drinking in the past 30 days. These responses show how the risk behavior of youth has a potential impact on the unintentional injuries and deaths from motor vehicle crashes.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	25.6	26.2	26.2	32.8	32.1
Numerator	6527	6777	6860	8635	8436
Denominator	255029	258515	262314	263050	263050
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
From 2009 Virginia Department of Health Division of Disease Prevention data. 2009 denominator data not yet available. Entry is an estimate based on previous year.

Notes - 2008
From Virginia Department of Health Division of Disease Prevention data and NCHS population estimates, 2008.

Notes - 2007
From Virginia Department of Health Division of Disease Prevention data and NCHS population estimates, 2007.

An attachment is included in this section.

Narrative:
Since 1999 there is no significant trend in the chlamydia rate for women 15 through 19. In 2008 the projected rate of chlamydia appears to increase significantly; however procedural changes can help to explain the increase. Prior to 2008, when the VDH's Division of Disease Prevention received confirmed chlamydia cases from laboratories, the cases were sent to the district health department of origin to obtain additional information. Once the information was obtained they were officially reported. After assessing this process, it was learned that the Division was not receiving information back on all of the cases. As a result the procedure for officially documenting and reporting chlamydia cases was changed. Since the laboratory confirms the cases the Division now counts them as officially reported cases whether they get back the additional

information that they requested from the district health department.

The Virginia Department of Health's Family Planning Clinics follow CDC guidelines for screening all young women below 25 years of age and retest positives at 3 months post treatment for re-infection. Virginia receives Infertility Prevention funds from CDC that requires collaboration among the STD program and our public health laboratory. These funds require screening for Chlamydia in family planning clinics. The STD program receives tests or reported positives from the local health departments as well as all labs that conduct testing for hospitals and doctors offices in the state. With limited funding VDH routinely screens the population most at risk - those under the age of 25.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.3	7.7	8.1	10.5	10.0
Numerator	9872	10541	11045	14150	13482
Denominator	1349807	1366993	1362173	1352925	1352925
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
From 2009 Virginia Department of Health Division of Disease Prevention data. 2009 denominator data not yet available. Entry is an estimate based on previous year.

Notes - 2008
From 2008 Virginia Department of Health Division of Disease Prevention data and NCHS population estimates.

Notes - 2007
From 2007 Virginia Department of Health Division of Disease Prevention data and NCHS population estimates.

An attachment is included in this section.

Narrative:
Since 1999 there is no significant trend in the chlamydia rate for women 20 through 44. In 2008 the projected rate of chlamydia appears to increase; however procedural changes can help to explain the increase. Prior to 2008, when the VDH's Division of Disease Prevention received confirmed chlamydia cases from laboratories, the cases were sent to the district health department of origin to obtain additional information. Once the information was obtained they were officially reported. After assessing this process, it was learned that the Division was not receiving information back on all of the cases. As a result the procedure for officially documenting and reporting chlamydia cases was changed. Since the laboratory confirms the cases the Division now counts them as officially reported cases whether they get back the additional information that they requested from the district health department.

The Virginia Department of Health's Family Planning Clinics follow CDC guidelines for screening all young women below 25 years of age and retest positives at 3 months post treatment for re-infection. Virginia receives Infertility Prevention funds from CDC that requires collaboration among the STD program and our public health laboratory. These funds require screening for Chlamydia in family planning clinics. The STD program receives tests or reported positives from the local health departments as well as all labs that conduct testing for hospitals and doctors offices in the state

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	107004	70248	25374	564	6052	154	4612	0
Children 1 through 4	415668	281373	90626	1610	22640	608	18811	0
Children 5 through 9	497586	343573	107674	1825	24227	636	19651	0
Children 10 through 14	490349	339163	111468	1795	22006	446	15471	0
Children 15 through 19	535634	367518	132368	1979	20716	480	12573	0
Children 20 through 24	545435	384647	125517	2373	21102	587	11209	0
Children 0 through 24	2591676	1786522	593027	10146	116743	2911	82327	0

Notes - 2011

Narrative:
The needs assessment process has included a review of changes in the Virginia's demographic data. Compared to the demographic data presented in the 2010 Title V application there appears to be an across the board increase in each age category by race. There is no significant increase in any one category.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	92469	14535	0
Children 1 through 4	360757	54911	0
Children 5 through 9	446864	50722	0
Children 10 through 14	451937	38412	0
Children 15 through 19	500229	35405	0
Children 20 through 24	503668	41767	0

Children 0 through 24	2355924	235752	0

Notes - 2011

Narrative:
The needs assessment process has included a review of changes in the Virginia's demographic data. Compared to the demographic data presented in the 2010 Title V application there appears to be a slight increase in the percent of Hispanic children. In the 2010 application, 8.8% of children were identified as Hispanic and currently 9.1% are Hispanic.

Adequately serving Hispanic and other non-English speaking groups has challenged language resources, however the need to deliver services in culturally appropriate ways is also challenging. The Virginia Department of Health's Office of Minority Health and Public Health Policy has developed a number of resources to address culturally and linquistically appropriate health care. Resources include educational sessions, assessment tools, commonly used clinical phrases in different languages, policies and regulations and links to research and other resources such as links to interpreter services. These resources can be found on the Office of Minority Health and Public Health Policy website http://www.vdh.state.va.us/healthpolicy/healthequity/clasact.htm.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	106	41	60	0	0	0	5	0
Women 15 through 17	2369	1263	1003	4	19	0	78	2
Women 18 through 19	6427	3762	2414	11	61	3	174	2
Women 20 through 34	80334	55254	17349	135	5528	23	2000	45
Women 35 or older	17335	12658	2477	22	1813	8	346	11
Women of all ages	106571	72978	23303	172	7421	34	2603	60

Notes - 2011

Narrative:
In 2008, there were 106,571 live births in Virginia. Approximately 2.3% of the births were to teens aged 17 and younger. In 2007, there were approximately 2.5% of the births to teens. The Teen Pregnancy Prevention Initiative (TPPI) programs, mandated by the Virginia General Assembly, are located in Richmond, Norfolk, Roanoke city, Crater, Portsmouth, and Eastern Shore health districts. These sites were mandated due to historically high teen pregnancy rates. Although all of the programs are community-based and have common components, they are uniquely designed to serve the needs of their communities. Over the years funding to support TPPI has varied with only state support some years and more recently a combination of state funds and TANF. For FY 2011, the funding has been decreased to less that half the original funds due to the elimination of TANF funding. The reduction will have a major impact on the local TPPI

programs.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	82	24	0
Women 15 through 17	1952	410	7
Women 18 through 19	5545	873	9
Women 20 through 34	69161	11058	115
Women 35 or older	15430	1883	22
Women of all ages	92170	14248	153

Notes - 2011

Narrative:
In 2008 there was a total of 106,571 live births in Virginia. Of this number, 13.4% were Hispanic births. This is very similar to the birth statistics from 2007 with 13.8% of births being Hispanic. Approximately 78% of the Hispanic births were to women age 20 through 34 years. This is similar to the non-Hispanic birth statistics with births to non-Hispanic women ages 20 through 34 accounting for 75% of births. The percent of births to teens 17 and younger was also very similar. Approximately 3% of all Hispanic births were to teens 17 and younger while 2% of non Hispanic births were to teens. This is unchanged from 2007.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	716	390	285	3	29	1	2	6
Children 1 through 4	96	64	25	2	4	0	1	0
Children 5 through 9	48	27	19	0	2	0	0	0
Children 10 through 14	69	47	18	1	3	0	0	0
Children 15 through 19	339	231	102	0	6	0	0	0
Children 20 through 24	487	318	151	1	16	0	0	1
Children 0 through 24	1755	1077	600	7	60	1	3	7

Notes - 2011

Narrative:
In 2008 there were 1,755 children aged 0 through 24 that died in Virginia. In all age categories, African Americans were over represented. In 2008, a total of 716 infants died in the state. This is 123 fewer infant deaths than 2007. Of these infants, approximately 40% were African Americans. Approximately 88% of all child deaths occurred in either infants or children ages 15 through 24 years.

VDH's Division of Injury and Violence Prevention (DIVP) promotes child safety through public information, training, community education and events, and support for community coalitions. The unintentional injury programs focus on the prevention of the leading causes of fatal and non-fatal unintentional injuries including child passenger safety, fire and burn prevention, traumatic brain injury prevention and general injury prevention outreach, education and policy. The division distributes materials through its resource center, provides program consultation and technical assistance, and serves as the consumer product safety liaison for Virginia. Many childhood injury prevention services are provided through broad-based coalitions.

The DIVP's Child Transportation Safety Program provides consultation and coordinates statewide information campaigns on child transportation safety issues such as motor vehicle passenger safety and bike safety. They provide technical assistance to individuals and agencies pertaining to the proper installation of child safety seats. In addition the division provides free child safety seats and booster seats to low income families and support local events where the public can learn how to properly install their safety seat. The division also oversees the training of nationally certified child passenger safety technicians and provides training on the safe transportation of children in child care and children with special needs.

The Virginia State Child Fatality Review Team is a surveillance project that examines child deaths to determine whether the death could have been prevented and to make recommendation for education, training and prevention strategies. The membership includes physicians and representatives from state and local agencies who provide services to children or who may be involved in the investigation of the death. Over the years, the team has produced reports on such topics as child deaths from heat-related motor vehicle entrapment deaths, motor vehicle deaths, caretaker homicide and suicide.

The Commissioner's Infant Mortality Workgroup has implemented a program, text4baby, that provides 3 free text messages each week to pregnant women and new mothers who sign up for the service by texting BABY to 511411 (or BEBE for Spanish). The messages are timed to the due date or baby's date of birth and cover such topics that include birth defects prevention, nutrition, mental health, oral health and safe sleep. The messages also connect women to prenatal and infant care services and other resources.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	614	87	15
Children 1 through 4	87	8	1
Children 5 through 9	44	3	1
Children 10 through	64	3	2

14			
Children 15 through 19	321	14	4
Children 20 through 24	441	39	7
Children 0 through 24	1571	154	30

Notes - 2011

Narrative:
In 2008 a total of 1,725 children and youth between the ages of 0 through 24 died in Virginia. Of this number, 154 Hispanic children died (approximately 8.9% of the total). The majority of Hispanic deaths occurred in the infant age group (87 deaths) and the 15 through 24 year old age group (53 deaths). This is similar to the non-Hispanic population of children.

VDH's Division of Injury and Violence Prevention (DIVP) promotes child safety through public information, training, community education and events, and support for community coalitions. The unintentional injury programs focus on the prevention of the leading causes of fatal and non-fatal unintentional injuries including child passenger safety, fire and burn prevention, traumatic brain injury prevention and general injury prevention outreach, education and policy. The division distributes materials through its resource center, provides program consultation and technical assistance, and serves as the consumer product safety liaison for Virginia. Many childhood injury prevention services are provided through broad-based coalitions.

The DIVP's Child Transportation Safety Program provides consultation and coordinates statewide information campaigns on child transportation safety issues such as motor vehicle passenger safety and bike safety. They provide technical assistance to individuals and agencies pertaining to the proper installation of child safety seats. In addition the division provides free child safety seats and booster seats to low income families and support local events where the public can learn how to properly install their safety seat. The division oversees the training of nationally certified child passenger safety technicians and provides training on the safe transportation of children in child care and children with special needs.

The Virginia State Child Fatality Review Team is a surveillance project that systematically examines child deaths to determine whether the death could have been prevented and to make recommendation for education, training and prevention strategies. The membership and the purpose of the team are legislatively mandated and include physicians and representatives from state and local agencies who provide services to children or who may be involved in the investigation of the death. Over the years, the team has produced reports on such topics as child deaths from heat-related motor vehicle entrapment deaths, motor vehicle deaths, caretaker homicide and suicide.

The Commissioner's Infant Mortality Workgroup has implemented a program, text4baby, that provides 3 free text messages each week to pregnant women and new mothers who sign up for the service by texting BABY to 511411 (or BEBE for Spanish). The messages are timed to the due date or baby's date of birth and cover such topics that include birth defects prevention, immunization, nutrition, mental health, oral health and safe sleep. The messages also connect women to other resources.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	2046241	1401875	467510	7773	95641	2324	71118	0	2008
Percent in household headed by single parent	12.2	9.6	21.5	15.6	6.0	10.2	6.8	9.2	2008
Percent in TANF (Grant) families	3.7	1.7	8.9	1.8	0.9	0.0	0.0	15.0	2009
Number enrolled in Medicaid	343157	129087	168554	522	7395	1777	384	35438	2007
Number enrolled in SCHIP	72556	32173	24965	192	2595	283	26	12322	2007
Number living in foster home care	6459	3324	2621	8	32	7	375	92	2009
Number enrolled in food stamp program	375940	154400	170562	565	4319	0	0	46094	2009
Number enrolled in WIC	211441	119763	74818	2677	4712	395	7646	1430	2009
Rate (per 100,000) of juvenile crime arrests	3601.0	0.0	0.0	0.0	0.0	0.0	0.0	3601.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.5	1.6	3.7	0.0	0.8	0.0	0.0	0.1	2008

Notes - 2011
Data from Census Population Estimates, 2008.

Data from Virginia Department of Social Services, Division of Strategy Management and Research, 2009. TANF cases include children less than 18 years old. The categories Native Hawaiian or Other Pacific Islander and More Than One Race Reported were not included due to concerns from DSS about data integrity.

Data from Virginia Department of Social Services, Division of Strategy Management and Research, 2009. Food stamp enrollment includes children less than 18 years old. The categories Native Hawaiian or Other Pacific Islander and More Than One Race Reported were not included due to concerns from DSS about data integrity.

Data from Virginia WIC program, CY2009.

Numerator from Crime in Virginia 2008 published by the Virginia State Police, Denominator from Census Population Estimates from 2008.

Data from Virginia Department of Education. Dropout rates are calculated using children enrolled in grades 9-12 Fall membership 2007 as the denominator and the criteria for a dropout are as follows:
A dropout is an individual who:
(1) Was enrolled in school at some time during the previous school year and was not enrolled on October 1 of the current school
(2) Was not enrolled on October 1 of the previous school year although expected to be in membership; and
(3) Has not graduated from high school or completed a state- or district-approved educational program; and
(4) Does not meet any of the following exclusionary conditions:
(i) Transfer to another public school district, private school, or state- or district-approved education program;
(ii) Temporary school-recognized absence due to suspension or illness;
(iii) Death.

Narrative:
In 2008 the Virginia population contained an estimated 2,046,241 children aged 0 through 19. African American children made up approximately 23% of the total child population, while white children made up 69%. Approximately 22% of the African Amercian children live in single parent households and are over represented in enrollment in Medicaid (49%), TANF (8.9%), SCHIP (34%), foster care (41%), food stamps (45%), and WIC (35%). African Americans also have the highest percent of high school drop-outs (3.7%). The juvenile crime arrest data by race are not available. However as a whole, the rate of junvenile crime arrests was 3,601 per 100,000 in 2008.

The ecomonic downturn with a resulting loss of employment is reflected in the increasing percent of children living in families receiving WIC and Food Stamps. In 2007 approximately 8.3% of children received WIC compared to 10.3% in 2008. The percent of children living in families receiving Food Stamps has increased from 12.8% in 2007 to 18.4% in 2008.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1852256	193985	0	2008
Percent in household headed by single parent	12.2	5.4	0.0	2008
Percent in TANF (Grant) families	3.4	5.3	0.0	2009
Number enrolled in Medicaid	308499	34658	0	2007
Number enrolled in SCHIP	61375	11181	0	2007
Number living in foster home care	5851	608	0	2009
Number enrolled in food stamp program	314295	47180	14465	2009
Number enrolled in WIC	167783	42231	1427	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	3601.0	2008
Percentage of high school drop-outs (grade 9 through 12)	2.4	4.2	0.0	2008

Notes - 2011
Data from Census Population Estimates, 2008.

Data from Virginia Department of Social Services, Division of Strategy Management and Research, 2009. TANF cases include children less than 18 years old. The categories Native Hawaiian or Other Pacific Islander and More Than One Race Reported were not included due to concerns from DSS about data integrity.

Data from Virginia Department of Social Services, Division of Strategy Management and Research, 2009. Food stamp enrollment includes children less than 18 years old. The categories Native Hawaiian or Other Pacific Islander and More Than One Race Reported were not included due to concerns from DSS about data integrity.

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Numerator from Crime in Virginia 2008 published by the Virginia State Police, Denominator from Census Population Estimates from 2008.

Data from Virginia Department of Education. Dropout rates are calculated using children enrolled in grades 9-12 Fall membership 2007 as the denominator and the criteria for a dropout are as follows:
A dropout is an individual who:
(1) Was enrolled in school at some time during the previous school year and was not enrolled on October 1 of the current school
(2) Was not enrolled on October 1 of the previous school year although expected to be in membership; and
(3) Has not graduated from high school or completed a state- or district-approved educational program; and
(4) Does not meet any of the following exclusionary conditions:
(i) Transfer to another public school district, private school, or state- or district-approved education program;
(ii) Temporary school-recognized absence due to suspension or illness;
(iii) Death.

Narrative:
In 2007, an estimated 2,046,241 children aged 0 through 19 were residents of Virginia. Of this number, approximately 9.5% were Hispanic. The percent of Hispanic children living in a single parent household was lower than the non-Hispanic children (5.4% vs. 12.2%). However, the Hispanic families were more likely to be enrolled in TANF (4.2% vs. 3.2%), Medicaid (18.8% vs. 16.6%), WIC (20.8% vs. 8.3%), and SCHIP (6% vs. 3.3%) than non-Hispanic families. In 2007 the percent of Hispanic and non-Hispanic enrolled in the Food Stamp Program was comparable. In 2008, the enrollment in the Food Stamp program reflects the changing economics. Hispanics had a much higher percent enrolled in the Food Stamp program than non-Hispanic children (24.3% vs. 17%). Hispanic children were more likely to be high school drop-outs than non-Hispanic children (4.2% vs. 2.4%).

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1632019
Living in urban areas	1523422
Living in rural areas	522819

Living in frontier areas	0
Total - all children 0 through 19	2046241

Notes - 2011

Narrative:
In 2008 Virginia's total population reached approximately 7.8 million. The state's 11 metropolitan areas contained about 86% of the total population. Approximately 74% of all children aged 0 through 19 years live in urban areas while approximately 26% live in rural areas. Access to care, including transportation, and other resources are more limited to the children living in rural areas of the state.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	7518394.0
Percent Below: 50% of poverty	4.4
100% of poverty	10.2
200% of poverty	24.3

Notes - 2011
From the American Community Survey, 2008

Poverty data from the American Community Survey, 2008

Poverty data from the American Community Survey, 2008

Poverty data from the American Community Survey, 2008

Narrative:
In the Virginia Department of Health, there is an increasing interest in the area of health equity. Income and poverty are strong predictors of health because they influence access to resources and opportunities. The VDH Office of Minority Health and Public Health Policy recently published the Virginia Health Equity Report 2008. The report provides data on poverty level and shows that the African American population is twice as likely to live in poverty as the white population. Hispanics were 1.5 times more likely to live in poverty than whites. The report also shows the impact of socioeconomic status on health. The report offers intervention recommendations that include increasing awareness of health inequities and the need for comprehensive strategies for elimination, the need to regularly monitor health inequities and support health care efforts that focus on access to quality and culturally/linguistically appropriate services. The Virginia Health Equity Report may be viewed on the following the VDH's Office of Minority Health and Public Health Policy's web site:http://www.vdh.state.va.us/healthpolicy/documents/health-equity-report-08.pdf.

VDH staff participate in the planning of the first Health Equitiy Conference that was held in Richmond. Over 300 individuals participated in the confernce. National known speakers presented research on the implications of social determinants of health and the outcomes of health inequities.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	2046241.0
Percent Below: 50% of poverty	5.0
100% of poverty	11.8
200% of poverty	26.9

Notes - 2011
Child Population total from the Current Population Survey, 2008

Poverty data from the American Community Survey, 2008

Poverty data from the American Community Survey, 2008

Poverty data from the American Community Survey, 2008

Narrative:
There are an estimated 2,046,241 children 0 through 19 years old in Virginia. It is estimated that in 2008, over a quarter (26.9%) of the children live at 200% of the poverty level and that 5% of the children experience extreme poverty living below 50% of the federal poverty level. According to the Virginia Health Equity Report 2008, African American children were 3 times more likely to live in poverty than white children and that African American children accounted for 47% of all children living in poverty in Virginia. Hispanic children accounted for 7% of all children living in poverty in the state and are 1.7 times more likely to live in poverty than white children. White children accounted for 44% of all children in poverty and Asian children accounted for 3% of all children in poverty.

F. Other Program Activities

In 2010, VDH's NuPAFP has partnered with University Virginia's Office of Continuing Medical Education for educational design, accreditation services, participation tracking and implementation of an interactive learning program designed to provide physicians and healthcare professionals about nutrition. The educational modules include a framework of infant & child feeding practices, a review the developmental milestones of infant & child development with regards to feeding practices, the current epidemiology of childhood obesity and evidence-based practices in obesity prevention, and other information

Through multi-sector partnerships with WIC, the VA Breastfeeding Advisory Committee, the VA Foundation for Healthy Youth, Anthem BCBS, VA AAP, and others, VDH is implementing proven approaches such as strategies to improve nutrition and physical activity for children, promoting lactation support services for increasing breastfeeding duration, and expanding school-age nutrition and physical activity programming for obesity prevention statewide. In addition, through local partnerships with health and wellness coalitions, CHAMPION recommended programs targeting schools, communities, families, and worksites have reached each region of Virginia.

In February 2010, VDH received funding through the Communities Putting Prevention to Work (CPPW) initiative through ARRA to directly support states and territories in promoting wellness

and preventing chronic disease through state-wide and local policy, the built environment and environmental change as well as expanding tobacco cessation quitlines for chronic disease prevention. This grant opportunity represents collaboration between many internal and external partners to leverage current resources and expand the reach of policy and environmental changes statewide to promote healthy communities. VDH applied for funding to directly impact the health of young and school age children through breastfeeding support and promotion at worksites and licensed child day centers, promotion of Safe Routes to School, and supporting healthy vending options.

Project RADAR is a provider-focused initiative to promote the identification, assessment, treatment, and referral of victims of intimate partner violence (IPV) in the health care setting. From October 2008-October 2009, Project RADAR supported fifteen community-based training forums for healthcare providers and victim advocates, five regional train-the-trainer sessions, and at least 50 workshops for medical providers and students throughout the state. Over 2,000 providers received training on the RADAR methodology and140 healthcare and advocacy professionals were certified to instruct using the RADAR curriculum. More than 20,000 written resources for patients and providers were disseminated at these training events, upon requests of providers and advocates, and at health fairs and other events.

In 2009, VDH also published a report of findings from the 2008 Hospital Policy Analysis Project, in which Project RADAR program staff collaborated with a research team from Old Dominion University to review and make recommendations to nearly three-quarters of Virginia's hospitals regarding their policies on IPV. This report and the recommendations therein were presented as a poster at the National Conference on Health Care and Domestic Violence.

In 2010, DIVP continues to do statewide provider training and is funding four community forums on IPV and three hospitals to implement policy strategies to improve their response to IPV. DIVP is one of ten sites that was recently awarded to implement Project Connect: A Coordinated Public Health Initiative to Prevent Violence against Women, administered through the Family Violence Prevention Fund and funded by the Office on Women's Health of the U.S. Department of Health and Human Services. Project connect sites will be working to develop comprehensive models of public health prevention and intervention that can lead to improved health and safety.

In 2009, DIVP continued work on teen dating violence prevention. DIVP completed three, full day trainings on the Safe Dates, teen dating violence prevention curriculum. These trainings were provided to 100 key staff in the Montgomery County, Chesterfield County and Prince William County School Districts. These districts were also implementing the Olweus Bully Prevention Program. As a result of the training, Freedom High School in Prince William County presented the Safe Dates curriculum to all 10th grade students (approximately 400). In 2010, DIVP funded six agencies to implement activities from CDC's Choose Respect Dating Violence Prevention campaign.

In 2006, Virginia established a Home Visiting Consortium made up of representatives from 10 early childhood home visiting programs that receive state funds and serve families of children from pregnancy through age 5 in order to improve efficiency and effectiveness. The consortium initially reported to the Governor's Working Group on Early Childhood Initiatives and is part of Virginia's Plan for Smart Beginnings. Under the new governor, the early childhood initiatives will be reporting to the Early Childhood Advisory Council which is required by Head Start regulations to consist of high level administrative representatives from multiple agencies and parent representatives. The Consortium has identified core knowledge areas and is developing 12 modules as a basic training for all early childhood home visitors to complete by December 2011. Depending on the topic, modules will be available on the web and in live sessions. Under a contract with the Consortium, James Madison University (JMU) developed a web site (www.homevisitingva.com) where home visitors register and have individual training folders, and where documents about home visiting in Virginia, an interactive map for locating services and some national home visiting documents are available. In addition, the Consortium has pilot

system enhancement projects other VDH divisions with the Oral Health Workforce grant, on identifying intimate partner violence, and on promoting developmental screening and connections to the medical home. The Consortium has identified core data elements and is exploring ways to connect all home visiting programs' data entry in order to evaluate outcomes at school entry. The coming year will focus on developing local home visiting coalitions and enhancing the state system of home visiting services as a result of the recent health care reform legislation.

G. Technical Assistance

The Office of Family Health Services has developed new MCH priorities for the next five year. Although the priorities are currently being addressed to different degrees through existing initiatives, there is a need to reexamine the focus of the office and develop strategic plans around each of the priorities. In addition to having new MCH priorities, the office has a new director, Dr. Diane Helentjaris and work has begun on reorganizing the office in order to maximize both efficiencies and our effectiveness. Assistance from an outside consultant or experienced Title V director/staff from another state would be beneficial as the office engages in strategic planning around the new Title V priorities.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	12345316	12345316	12525377		12345316	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	9258987	9112232	9394033		9313133	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	1500000	1646756	685734		1500000	
7. Subtotal	23104303	23104304	22605144		23158449	
8. Other Federal Funds *(Line10, Form 2)*	74903855	130632139	113286550		130632139	
9. Total *(Line11, Form 2)*	98008158	153736443	135891694		153790588	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1848344	1690906	2912436		2218013	
b. Infants < 1 year old	4158775	1848344	1321960		3349020	
c. Children 1 to 22 years old	7162334	7366740	7393106		7162334	

d. Children with Special Healthcare Needs	8548592	10225493	8961340		7500000	
e. Others	1386258	1972821	2016302		1694551	
f. Administration	0	0	0		1234531	
g. SUBTOTAL	23104303	23104304	22605144		23158449	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		93713	
c. CISS	142917		105000		132000	
d. Abstinence Education	0		0		0	
e. Healthy Start	1050000		1050000		1050000	
f. EMSC	0		0		0	
g. WIC	61511469		98265995		114690471	
h. AIDS	0		0		0	
i. CDC	5367526		6547162		7811979	
j. Education	0		0		0	
k. Other						
DMAS	447500		447500		447500	
Family Planning	4527671		4677670		4797671	
MCHB	284978		633579		1108805	
SAMSHA Youth Suicide	400000		500000		500000	
TANF	1077150		965000		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	15017797	15530671	16049653		13980096	
II. Enabling Services	1848344	1704517	678154		2218013	
III. Population-Based Services	3465645	3115821	2260514		3738985	
IV. Infrastructure Building Services	2772517	2753295	3616823		3221355	
V. Federal-State Title V Block Grant Partnership Total	23104303	23104304	22605144		23158449	

A. Expenditures

Form 3: Matching expenditures for Virginia's Maternal and Child Health Services listed on Form 3 totaled $10,646,756. Total general fund (state) expenditures totaled $9,122,232, which falls below the projection of $9,258,987 by $136,755. This is the result of ongoing budget shortfalls in the Commonwealth necessitating restrictions on state funded expenditures. However, $1,645,919 in expenditures consisted of special funding allowing Virginia to exceed its program income requirement by $146,756 resulting in Virginia's ability to fund the Virginia's Maternal and Child Health program at the level of $23,104,303.

Form 4: Expenditures for pregnant women served fell short of that budgeted by only $157,438. This population comprises approximately 7% of the total population served; expenditures for this population are consistent with the percentage of total MCH expenditures for this population. The expended amount is based on the actual visits while the budgeted amount is an estimate based on the prior year's visits.

Infants less than one year old comprise approximately 7% of the population served; expenditures for this population are consistent with that percentage. Expenditures, however, fell short of that projected for several reasons, primarily a shift in expenditures to Children with Special Health Care Needs program (relocation of a major care coordination site, increased demand for services). Expenditures for services to children 1 to 22 years of age fell closely in line with the amount budgeted and exceed budget by only $204,406 ($7,366,740 expenditures versus $7,162,334 budget). Expenditures for Others exceeded budget by $586,563, as the result of increased demand for safety net services related to declining economic environment.

Form 5: Direct Health Care Services expenditures exceeded budget projections by only approximately 3.5% and are lower than in previous years. This continues a trend of decline in support for direct services as Virginia continues to focus its resources on Enabling, Population-Based, and Infrastructure Building services. Expenditures for Enabling services fell below the budget projection of $1,848,344 by only $143,827, or 8%. Population-Based and Infrastructure Building services expenditures fell within budgeted expenditures, but were less than expected due to limitations on expenditures (travel, hiring, discretionary spending) during a time of economic downturn.

B. Budget

The Title V block grant budget provides funds for Maternal and Child Health (MCH) services, primary care for children and adolescents, and preventive and maintenance services to Children with Special Health Care Needs (CSHCN). Preventive and primary care services include policy and procedural oversight, nutrition services, Local Health Department (LHD) agreements, pharmacy and laboratory testing, Regional Perinatal Councils (RPCs), Fetal/Infant Mortality Review, Newborn screening/follow up, and reducing health problems and risk factors. Other services provided are promotion of health and provision of comprehensive health services, assessment, management of secondary and tertiary care, injury prevention, Child Care Nurse Consultant, Resource Mothers (RM), primary care, school health, family planning (under age 22), teen pregnancy prevention, maternal health (under age 22), laboratory testing, pharmacy, sickle cell services, and dental health.

Population services include policy and procedural oversight concerning women's services, agreements with LHD for family planning services, laboratory testing and pharmacy services.

Services for CSHCN include family-centered, community-based coordinated care for persons from birth through age 20 who have or are at risk for disabilities, handicapping conditions, chronic illnesses and conditions or health related educational or behavioral problems, and development of community-based systems of care for such children and families.

Virginia budgets 30% or more of MCH funding for preventive and primary care services for children. At least 30% (32% for FFY2011) is budgeted for CSHCN. The remaining funds will be used for infants, children, pregnant women, mothers, and non-pregnant women over 21 years. These shifts are the result of the effort the align funding with the true distribution of populations served. Please see details below:

Groups Served:	Budget	% of Total Budget
Pregnant Women	2,218,013	10%

Infants < 1 Year Old	3,349,020	14%
Children 1 to 22 Years Old	7,162,334	31%
CSHCN	7,500,000	32%
Others	1,694,551	7%
Administration	1,234,531	5%
Total:	23,158,449	100%

Service Type:	Budget	% of Total Budget
Direct Health Care Services	13,980,097	60%
Enabling Services	2,218,013	10%
Population-Based Services	3,738,985	16%
Infrastructure Building Services	3,221,355	14%
Total:	23,158,449	100%

Administration: Administrative costs are incurred by the Virginia Department of Health (VDH) in administering grants by individuals other than those solely supporting the grant. As in previous years, the Federal Fiscal Year (FFY) 2011 budget does not include administrative costs. VDH's definition of administrative costs includes management and policy direction, accounting and budgeting services, personnel services, and support services for supplies, equipment, etc. State funds provided for FY2011 for MCH exceed the fiscal year 1989 level. Between October 1988 and September 30, 1989 (FY89), $9,122,232 in state funds for Title V services was expended; the FY2011 state allocation is $9,313,133; program income is again budgeted at $1,500,000. However, as in previous years, if program income does not meet projections, spending will be adjusted accordingly.

During FY89, $9,033,260 in federal fund was expended and Virginia overmatched the 4:3 requirement by $1,943,058. State funds expended in 1989 included all funds used for the Title V match and overmatch for all Title V-funded units and for childhood immunization. Title V funds are used to carry out the purposes of this title and the following activities previously conducted under the Consolidated Health Programs: Lead poisoning prevention and Genetics. Virginia did not receive Sudden Infant Death Syndrome (SIDS) funds; however, the Division of Women's and Infants' Health provides information to families of SIDS infants. Based on the State's previous use of funds under this title, a reasonable proportion of allotted funds will be used to carry out the purposes described in Section 501(a)(1)(A) - (D). The total budget is estimated to be $23,158,449.

Title V funds will be used for preventive and primary care services for pregnant women, non-pregnant women of child bearing age, mothers, infants, children, adolescents, and families. These funds will be used for family planning, LHD prenatal and child health services, genetic testing/counseling/ pharmacy and education, RPCs, primary care, injury prevention, oral health programs, and local programs to reduce infant mortality. These services meet Section 501(a)(1)(A) and (B). Title V funds ($8,548,592) will be used for CSHCN, meeting purposes in Section (a)(1)(C) and (D).

Additional federal funds: Centers for Disease Control and Prevention (CDC) programs total $11,708,262; of this, $7,811,979 is targeted to MCH populations. Funds for Healthy Start are $1,050,000; SSDI, $93,713; and CISS, $132,000. Virginia no longer holds an Abstinence Education grant.

Another source of MCH targeted funding is the Women, Infants, and Children (WIC) nutrition program estimated to be $114,690,471. Maternal and Child Health Bureau additional funds include Universal Hearing Screening ($150,000) and Targeted Oral Health totaling $160,000, Oral health Workforce ($499,485), and Systems Improvement for CSHCN ($299,320), for a total of $1,108,805. In FY11, $6,853,976 in "other" federal funds includes: Department of Medical Assistance Services for the Resource Mothers Program ($447,500). Title X provides $4,797,671 and SAMSHA funds Youth Suicide Prevention at $500,000.

There are no known unobligated balances for the state fiscal year ending June 30, 2010. Funds will be used to enhance enabling, population-based services and infrastructure activities and to support innovative research-based pilot projects.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.